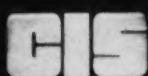


NOTE

This Microfiche meets the quality requirements of the American National Standard for Microfiche of Documents (ANSI PH5.9-1975). However, because of imperfections in the document from which it was made, it contains images that are illegible or difficult to read. The source document for this microfiche is the best copy that could be obtained prior to filming.



Congressional Information Service, Inc.
Washington, D.C.

CATASTROPHIC HEALTH INSURANCE: THE HOME CARE BENEFIT

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE OF THE SELECT COMMITTEE ON AGING HOUSE OF REPRESENTATIVES NINETY-NINTH CONGRESS SECOND SESSION

MARCH 19, 1986

Printed for the use of the Select Committee on Aging
Comm. Pub. No. 99-562



U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1986

59-866 O

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

H141-37

SELECT COMMITTEE ON AGING

EDWARD R. ROYBAL, California, *Chairman*

CLAUDE PEPPER, Florida
MARIO BIAGGI, New York
DON BONKER, Washington
THOMAS J. DOWNEY, New York
JAMES J. FLORIO, New Jersey
HAROLD E. FORD, Tennessee
WILLIAM J. HUGHES, New Jersey
MARILYN LLOYD, Tennessee
STAN LUNDINE, New York
MARY ROSE OAKAR, Ohio
THOMAS A. LUKEN, Ohio
BEVERLY B. BYRON, Maryland
DAN MICA, Florida
HENRY A. WAXMAN, California
MIKE SYNAR, Oklahoma
BUTLER DERRICK, South Carolina
BRUCE F. VENTO, Minnesota
BARNEY FRANK, Massachusetts
TOM LANTOS, California
RON WYDEN, Oregon
GEO. W. CROCKETT, Jr., Michigan
WILLIAM HILL BONER, Tennessee
IKE SKELTON, Missouri
DENNIS M. HERTEL, Michigan
ROBERT A. BORSKI, Pennsylvania
RICK BOUCHER, Virginia
BEN ERDREICH, Alabama
BUDDY MacKAY, Florida
HARRY M. REID, Nevada
NORMAN SISISKY, Virginia
ROBERT E. WISE, Jr., West Virginia
BILL RICHARDSON, New Mexico
HAROLD L. VOLKMER, Missouri
BART GORDON, Tennessee
THOMAS J. MANTON, New York
TOMMY F. ROBINSON, Arkansas
RICHARD H. STALLINGS, Idaho

FERNANDO TORRES-GIL, *Staff Director*

PAUL SCHLEGEL, *Minority Staff Director*

MATTHEW J. RINALDO, New Jersey,
Ranking Minority Member
JOHN PAUL HAMMERSCHMIDT, Arkansas
RALPH REGULA, Ohio
NORMAN D. SHUMWAY, California
OLYMPIA J. SNOWE, Maine
JAMES M. JEFFORDS, Vermont
THOMAS J. TAUKE, Iowa
GEORGE C. WORTLEY, New York
JIM COURTER, New Jersey
CLAUDINE SCHNEIDER, Rhode Island
THOMAS J. RIDGE, Pennsylvania
JOHN McCAIN, Arizona
GEORGE W. GEKAS, Pennsylvania
MARK D. SILJANDER, Michigan
CHRISTOPHER H. SMITH, New Jersey
SHERWOOD L. BOEHLERT, New York
JIM SAXTON, New Jersey
HELEN DELICH BENTLEY, Maryland
JIM LIGHTFOOT, Iowa
HARRIS W. FAWELL, Illinois
JAN MEYERS, Kansas
BEN BLAZ, Guam
PATRICK L. SWINDALL, Georgia
PAUL B. HENRY, Michigan
JIM KOLBE, Arizona
BILL SCHUETTE, Michigan
FLOYD SPENCE, South Carolina

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

CLAUDE PEPPER, Florida, *Chairman*

JAMES J. FLORIO, New Jersey
HAROLD E. FORD, Tennessee
MARY ROSE OAKAR, Ohio
THOMAS A. LUKEN, Ohio
DAN MICA, Florida
HENRY A. WAXMAN, California
MIKE SYNAR, Oklahoma
BUTLER DERRICK, South Carolina
BRUCE F. VENTO, Minnesota
BARNEY FRANK, Massachusetts
RON WYDEN, Oregon
IKE SKELTON, Missouri
DENNIS M. HERTEL, Michigan
ROBERT A. BORSKI, Pennsylvania
BEN ERDREICH, Alabama
BUDDY MacKAY, Florida
NORMAN SISISKY, Virginia

RALPH REGULA, Ohio,
Ranking Minority Member
GEORGE C. WORTLEY, New York
JIM COURTER, New Jersey
CLAUDINE SCHNEIDER, Rhode Island
THOMAS J. RIDGE, Pennsylvania
JOHN McCAIN, Arizona
SHERWOOD L. BOEHLERT, New York
JIM LIGHTFOOT, Iowa
JAN MEYERS, Kansas
PATRICK L. SWINDALL, Georgia
PAUL B. HENRY, Michigan
JIM KOLBE, Arizona

KATHLEEN GARDNER CRAVEDI, *Staff Director*

MARK BENEDICT, J.D., *Minority Staff Director*

CONTENTS

MEMBERS OPENING STATEMENTS

	Page
Chairman Claude Pepper	1
Ralph Regula	7
Ron Wyden	8
John McCain	10

CHRONOLOGICAL LIST OF WITNESSES

Panel One:	
Randy Kramer, cystic fibrosis victim, Miami, FL	11
Riva Fiterman, on behalf of her son Peter Fiterman, motorcycle accident victim, Chicago, IL	12
Barbara Oppen, wife of ALS victim, Chevy Chase, MD	17
Connie Fischer, mother of a child with "Edward's Syndrome," a genetic disorder, Grand Rapids, MI	18
Joanne Cooper, diabetic amputee, Akron, OH	21
Val Halamandaris, Esq., president, National Association for Home Care, Washington, DC	22
Panel Two:	
Hon. Joseph A. Califano, former Secretary of Health, Education, and Welfare, Washington, DC	34
Marvin Cetron, Forecasting International, Ltd., Arlington, VA	36
David Blumenthal, M.D., executive director, Center for Health Policy and Management, John F. Kennedy School of Government, Harvard University	46
Panel Three:	
Jack Guildroy, member, American Association of Retired Persons, National Legislative Council, Port Washington, NY	58
Marilyn Field, executive director, Utilization and Benefits Management, Blue Cross & Blue Shield Association, Washington, DC	68

APPENDIX

Additional material submitted for the record:	
Excerpt from "The Attempted Dismantling of the Medicare Home Health Benefit," submitted by Val Halamandaris, Esq., president, The National Association for Home Care	79
Charles Laff, executive director, In Home Health Care Service of Suburban Chicago North, Inc., Morton Grove, IL, letter	93
Eric A. Robba, mayor, town of Groton, CT, letter	96

CATASTROPHIC HEALTH INSURANCE: THE HOME CARE BENEFIT

WEDNESDAY, MARCH 19, 1986

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:10 a.m., in room 2359A, Rayburn House Office Building, Hon. Claude Pepper (chairman of the subcommittee) presiding.

Members present: Representatives Pepper, Wyden, and Regula.

Staff present: Kathleen Gardner Cravedi, staff director; Melanie Modlin, assistant staff director; Peter Reinecke, research director; Patricia Butch, congressional fellow; Ronald Schwartz, detailee; Ronald Scheid, detailee; Lanny Miller, detailee; Bill Halamandaris, consultant; Dr. Leonard Scherlis, consultant; Lillian Simmons, volunteer; Mark Benedict, minority staff director; and Patrick McCarthy, minority detailee.

OPENING STATEMENT OF CHAIRMAN CLAUDE PEPPER

Mr. PEPPER. The committee will come to order, please. I must admonish the reporter, and I want this in the record, please.

I must admonish the reporter that this is the first time in my congressional experience that the hearing has ever had to be delayed now a little over 10 minutes because the reporter was not here.

My staff advises me that your office has been notified since 8 o'clock this morning—are you taking this down?—

[Reporter nods affirmatively.]

Mr. PEPPER [continuing]. To be here at 10 o'clock when this meeting convened. Time is precious to us, and I must admonish you and I want it in the record that you have caused the committee to be tardy in its duty this morning because of your tardy arrival.

You may have had circumstances that justify your tardiness, but it is regrettable and we hope that you try to avoid it in the future, please.

Ladies and gentlemen, we are today having a very important hearing upon I think one of the most important matters gaining the American people's attention at the present time.

I have a prepared statement which will be submitted for the record. I would like just to summarize what that statement is and what my views are about this matter.

We are dealing with the problem of health care primarily for the elderly people of America. In the last few years the cost of medical care has risen three times as much as the cost of living.

While the cost of medical care for the people generally has increased about 50 percent, the cost of medical care for the elderly has increased a hundred percent.

In 1965 we enacted Medicare legislation. We were hopeful that that would pretty well take off of the shoulders of the elderly the cost of their medical care.

At that time they were paying about 20 percent of their gross income for their medical care. Now, they are paying almost exactly the same gross 20 percent of their income for their medical care that they were paying when Medicare was adopted in 1965.

Moreover, as a matter of fact only about 45 percent of the cost of medical care for the elderly is covered by the Medicare Program. For example, Medicare does not cover long-term care.

If one has Alzheimer's disease, unfortunately that causes long-term care. It requires long-term care. It is not covered by Medicare.

We had a lady testify before our hearing some time ago that she and her sister had provided medical care for their mother who had Alzheimer's disease, and within 3 months every penny they had would have been exhausted in the care, the loving care, they tried to give to their mother.

So today Medicare does not cover eyeglasses or any aid for the eye or eye operations. It does not cover hearing equipment or hearing care or treatment.

It does not cover drugs in the home other than in the hospital. Medicare does not cover things like transplants and the like which are often a devastating burden to be borne by the elderly who are fortunate enough to get them.

So we are very much concerned about the protection of the elderly against catastrophic illness costs. Now, the administration has made a considerable beginning, and we commend them for it.

Dr. Bowen, the new secretary of Health and Human Services, announced that he was in favor of a program to restrain catastrophic costs for people covered by Medicare.

Well, that is fine as far as it goes, but we had Dr. Bowen before our committee not long ago. We reminded him that according to our calculations, the cost of the program would be about \$14.00 a year for about 36 million elderly people, but only one-tenth of 1 percent would benefit from that program, namely those who stayed in the hospital more than 2 weeks.

Only a small percentage of the hospital patients stay in the hospital more than 2 months, but the idea of the administration being disposed to go forward is commendable.

We asked Dr. Bowen when he appeared before our committee, will you not, Doctor, consider comprehensive medical care—all costs to the elderly.

One illness may devastate the fortune of an elderly person, or for that matter anybody in the country. One of my dear brothers was in the hospital for 6 weeks, at home in Miami for a checkup.

He got a bill for \$26,350, and he had to be in the hospital twice more before he passed away. Fortunately that was covered by Medicare. He was worth about \$35,000 or \$40,000.

Everything he had would have been taken if he had not been covered by Medicare for that bill. There are lots of people that have savings of \$50,000 or even \$100,000 who think they are relatively secure.

Suppose they get the sad news that I received one time that their wife has cancer. It cost me \$40,000 just for extra nurses—around the clock—nurses not provided by the hospital, during the time that my wife had cancer. She lived 1½ years after getting notice that she had it.

So what we are talking about is trying to find some way that we can provide in America a health care system thoroughly American. I prefer to have it generated by the genius of American free enterprise.

I prefer to have it administered by a private enterprise so that the administration might be as efficient, and the least wasteful, as possible. I prefer the program to require everybody to pay what he or she can and should.

I hope to live to see the day when in our blessed America every man, woman, and child would be assured of getting the medical care that he or she should have.

I think that is a part of the American dream, and that is a part of the American goal. Now, one other aspect of this matter which is to be emphasized today is home care.

Regrettably I have to say that the administration at the time the need for home care is increasing is reducing the funds available for home care.

You will be told by the witnesses here of people who are in wheelchairs and have other disabilities of a most grievous character who are not able to get home care.

You will be told of other persons with cystic fibrosis who have to go twice a day to a hospital to get care that could be provided in the home.

I regret to say that the analogy in respect to the national policy is like the recent experience we had with the disabled.

At one time the administration determined that they were going to cut 30 percent off of the cost of caring, of giving a pension to the disabled in America under the general Social Security Program, and many times without a medical examination.

Men and women were stricken from the disability rolls and left to starve without regard for any aid and without any capacity to sustain themselves. I heard the Governor of Florida say that three people in that category in my State of Florida committed suicide because their pension funds were taken away from them, or their disability relief was withheld from them.

They did not have any subsistence, and they did not think they had any way to live, and they took their lives. So what we are talking about here is very similar. We are going to have outstanding witnesses like Hon. Joseph Califano who was Secretary of Health, Education and Welfare, and one of the architects of the Medicare Program, one of the most informed men in the country in this area.

We are going to be told about a magnificent survey of the Harvard Medical School in this area. So we are going to have today

some very important testimony, but it is all in the direction of two points of emphasis.

One is trying to cover catastrophic costs of illness particularly of a protracted nature, and the other one is the need for greater emphasis upon and provision for home care.

Nursing homes on the average today are costing \$30,000 to \$50,000 a year per patient. A great deal of expense could be saved by having proper care taken in the home.

You do not have to pay rent on a facility for an individual who already has a home either readied or purchased. So we are going to call important attention today to the needs for more emphasis upon providing home care.

Now, today is a very busy day here in Washington as the days usually are. I have got to run back over now and open up a hearing with the Rules Committee on some critical legislation that is up today.

Fortunately I have here my distinguished colleague, Hon. Ron Wyden, one of the great members of this committee. He has been one of the most farsighted and diligent of all the members of our subcommittee in forwarding the goals we seek to achieve.

He will preside in my absence, and I will return just as soon as I can. Thank you very much.

[The prepared statement of Chairman Pepper follows:]

PREPARED STATEMENT OF CHAIRMAN CLAUDE PEPPER

LADIES AND GENTLEMEN. MEMBERS OF THE SUBCOMMITTEE: I AM VERY PLEASED THAT OUR SUBCOMMITTEE IS HOLDING THIS SIGNIFICANT HEARING, THE SECOND IN OUR SERIES ON CATASTROPHIC HEALTH INSURANCE. THERE ARE FEW ISSUES OF GREATER IMPORTANCE TO THE NATION'S ELDERLY THAN THE FUTURE OF HEALTH CARE, AND SEVERAL FACTORS ACCOUNT FOR THIS CONCERN.

HEALTH CARE COSTS HAVE INCREASED THREE TIMES AS MUCH AS THE COST OF LIVING SINCE THE CREATION OF THE MEDICARE IN 1965. ALSO, WHILE THE COST OF HEALTH CARE HAS RISEN 50% FOR THE GENERAL POPULATION, IT HAS SKYROCKETED 100% FOR THE ELDERLY IN THE PAST 10 YEARS.

NURSING HOME SPACE IS LIMITED AND EXPENSIVE. THE AVERAGE ANNUAL BILL FOR A RESIDENT OF A NURSING HOME IS \$30,000-\$50,000. AND EVEN THOSE WHO CAN AFFORD THIS HIGH PRICE ARE OFTEN TURNED AWAY BECAUSE SPACE IS UNAVAILABLE.

INADEQUATE INSURANCE COVERAGE IS A GROWING PROBLEM. CURRENTLY, MEDICARE ONLY COVERS 45% OF AN OLDER PERSON'S OUT-OF-POCKET COSTS AND DOESN'T CONTRIBUTE TOWARD EYE, HEARING OR DENTAL CARE, PRESCRIPTION DRUGS ADMINISTERED OUTSIDE THE HOSPITAL, OR FOR NURSING HOME OR IN-HOME CARE FOR THE CHRONICALLY ILL. PRIVATE INSURANCE AFFORDS LITTLE OTHER ASSISTANCE -- IT ONLY MIRRORS MEDICARE AND SUPPLEMENTS ITS BENEFIT PACKAGE. AS A RESULT, MANY ELDERLY PERSONS FIND THEMSELVES EXPOSED FINANCIALLY TO THE RAVAGES OF CATASTROPHIC ILLNESS. ALTOGETHER, ABOUT 4 MILLION ELDERLY AND THEIR SPOUSES MAY BE PERMANENTLY PAUPERIZED BECAUSE NO INSURANCE WILL COVER THEIR LONG-TERM ILLNESSES.

AMERICA'S AGING POPULATION IS GROWING RAPIDLY. THE GRAYING OF THE POPULATION IS ONE OF THE MOST SIGNIFICANT DEMOGRAPHIC TRENDS OF THIS CENTURY. IN THE LAST TWO DECADES THE 65-PLUS POPULATION GREW TWICE AS FAST AS THE REST OF THE POPULATION -- AND THE OVER-85 AGE GROUP IS CURRENTLY THE FASTEST GROWING OF ALL. THIS IS ENCOURAGING NEWS -- A TESTAMENT TO IMPROVEMENTS IN MEDICAL CARE AND ELDERLY PEOPLE TAKING CARE OF THEMSELVES -- YET IT PRESENTS NEW CHALLENGES TO AMERICA'S HEALTH CARE SYSTEM TO CARE FOR THESE PERSONS.

AS THE SUBCOMMITTEE HAS LEARNED FROM MANY LETTERS RECEIVED FROM AROUND THE COUNTRY, THE REAL NIGHTMARE OF THE ELDERLY IS THE POSSIBILITY OF CONTRACTING A DRAWN-OUT ILLNESS, SUCH AS ALZHEIMER'S DISEASE OR CERTAIN TYPES OF CANCER. A BOUT WITH SUCH A DISEASE CAN MEAN THE END OF NORMAL LIFE AND VERY LIKELY FINANCIAL RUIN.

AT A RECENT HEARING OF THE SUBCOMMITTEE, WE WERE SHOCKED WHEN THE DAUGHTER OF AN ALZHEIMER'S PATIENT TESTIFIED, "MY DOCTORS TOLD ME THAT THE ONLY WAY TO GET ASSURED FINANCIAL ASSISTANCE FOR MY MOTHER WOULD BE TO BREAK HER ARM, AND HAVE HER PUT INTO A HOSPITAL. WHEN HER ARM HEALS, BREAK IT AGAIN, AND KEEP BREAKING IT IF YOU WANT TO ASSURE FINANCIAL ASSISTANCE." OF COURSE, HER DOCTOR WAS NOT SERIOUS ABOUT GOING TO SUCH LENGTHS, BUT THE POINT WAS WELL MADE: BECAUSE THE ESSENTIAL ELEMENTS OF TREATING ALZHEIMER'S DISEASE PATIENTS CAN BE PROVIDED IN THE HOME AND DO NOT REQUIRE HOSPITALIZATION, FINANCIAL ASSISTANCE IS NEGLIGIBLE. ACUTE CARE ILLNESSES ARE OFTEN WELL COVERED BY INSURANCE, BUT VICTIMS OF LONG-TERM ILLNESS HAVE TO GET BY AS BEST THEY CAN.

WHILE MOST AMERICANS RECOGNIZE THAT BOTH HOSPITALS AND NURSING HOMES PROVIDE A VALUABLE SERVICE, A NATIONAL SURVEY WHICH WILL BE RELEASED TODAY SHOWS THAT MOST AMERICANS FAVOR A POLICY WHICH WOULD CARE IN THE HOME. THE SURVEY ALSO REVEALS THAT AMERICANS FAVOR A POLICY OF CATASTROPHIC HEALTH INSURANCE FOR LONG-TERM ILLNESS AS WELL. A RECENT REPORT BY HARVARD AGREES WITH THIS NATIONAL SENTIMENT, AS WILL BE DETAILED IN TESTIMONY BY THEIR REPRESENTATIVE THIS MORNING.

I AM PLEASED THAT THE ADMINISTRATION HAS ALSO RECOGNIZED THE NEED TO PROVIDE CATASTROPHIC HEALTH CARE. WHAT DISTURBS ME IS THAT THE ADMINISTRATION IS ALSO CUTTING BACK ON THE MOST VITAL ELEMENT OF ANY CATASTROPHIC HEALTH PLAN -- THE HOME CARE BENEFIT.

HOME CARE PROLONGS A SENSE OF SELF-SUFFICIENCY. HOME CARE HAS THE POSITIVE EFFECT OF PERMITTING THE AGED AND INFIRM TO ENJOY THE COMFORT OF FAMILIAR SETTINGS. HOME CARE RELIEVES SOME OF THE PRESSURE ON INSTITUTIONS TO CARE FOR THE RAPIDLY GROWING ELDERLY POPULATION. AND, IN MANY CASES, HOME CARE CAN MEAN CONSIDERABLE SAVINGS TO AN AMERICAN HEALTH CARE SYSTEM ALREADY BATTLING SPIRALING COSTS.

DESPITE ALL THESE ADVANTAGES, THE HOME CARE BENEFIT IS DENIED TO MANY OLDER AMERICANS. AN ESTIMATED 5 MILLION PEOPLE ARE GOING WITHOUT THE HOME CARE THEY NEED AND DESERVE.

IN ADDITION, INCREASINGLY RESTRICTIVE ELIGIBILITY REQUIREMENTS ARE FORCING THOUSANDS OF HOME CARE RECIPIENTS TO JOIN THE 5 MILLION ALREADY GOING WITHOUT CARE.

LET ME GIVE YOU ONE STUNNING EXAMPLE OF THE DENIAL OF HOME CARE BENEFITS. ONE OF OUR WITNESSES TODAY IS A BLIND, DIABETIC, WHEELCHAIR-BOUND AMPUTEE WHO HAS BEEN DEEMED "NOT HOMEBOUND" BECAUSE THAT PERSON MUST BE DRIVEN TO A HOSPITAL SEVERAL TIMES A WEEK FOR DIALYSIS. BY NOT BEING "HOMEBOUND," ACCORDING TO THE GOVERNMENT'S DEFINITION, THIS SAD SOUL IS DENIED ALL HOME CARE BENEFITS.

ANOTHER OF OUR WITNESSES IS A VICTIM OF CYSTIC FIBROSIS, WHO REQUIRES ASSISTANCE TO BREATHE. SHE CANNOT RECEIVE THAT SUPPORT IN THE HOME BECAUSE MEDICARE DOES NOT COVER RESPIRATORY CARE IN THE HOME -- ONLY IN THE HOSPITAL. WE WILL HEAR HOW SHE MUST GO TO THE HOSPITAL TWICE DAILY TO RECEIVE HER NEEDED TREATMENT, AT A COST OF \$190 PER DAY. THE SAME TREATMENT COULD BE PROVIDED IN HER OWN HOME FOR ONLY \$60 A DAY.

WE WILL HEAR THESE STORIES AND OTHER TRAGIC INCIDENTS OF DENIAL OF HOME HEALTH BENEFITS ON THE BASIS OF SIMILAR RESTRICTIVE AND UNINTENDED INTERPRETATIONS OF THE HOME CARE BENEFIT.

RESTRICTIONS IN ELIGIBILITY FOR HOME CARE COME AT A TIME WHEN THE DEMAND FOR SUCH CARE IS INCREASING. THE NEWLY IMPLEMENTED PROSPECTIVE REIMBURSEMENT FOR HOSPITALS HAS RESULTED IN A 40% INCREASE OF PATIENTS DISCHARGED INTO HOME CARE. WITH SICKER PATIENTS BEING DISCHARGED, COMMUNITY HOME CARE SERVICES ARE PRESSED TO MEET THE GROWING NEED AND THE PATIENT IS OFTENTIMES LEFT TO PICK UP THE BILL.

THE HUMANITARIAN BENEFITS OF HOME CARE HAVE LONG BEEN RECOGNIZED. FOR THE VAST MAJORITY OF PEOPLE, IF PROPER MEDICAL CARE CAN BE GIVEN OR ASSISTANCE RENDERED, THEY ARE SO MUCH HAPPIER TO BE ABLE TO STAY IN THEIR OWN HOMES.

BUT, GIVEN RECENT DEVELOPMENTS, HOME CARE IS NOT JUST A NICETY. IT IS A DIRE NECESSITY.

WE LOOK FORWARD TO THE TESTIMONY OF OUR DISTINGUISHED WITNESSES TODAY. I KNOW THAT WE WILL BE ENLIGHTENED BY THEIR PERSONAL EXPERIENCES WITH HOME CARE AND THEIR SUGGESTIONS FOR REFORM OF THE AMERICAN HEALTH CARE SYSTEM.

Mr. WYDEN. The subcommittee is very fortunate today to have our distinguished friend and colleague, the gentleman from Ohio, Mr. Regula, who has had a long-standing interest in concerns of seniors. We are happy to recognize him for any comments that he chooses to make at this time.

STATEMENT OF REPRESENTATIVE RALPH REGULA

Mr. REGULA. Well, thank you, Mr. Chairman, and this is an important hearing as evidenced by the attendance of a great number of those who are interested in it.

I am hopeful that we can produce some constructive recommendations. I commend our chairman, Senator Pepper, for his diligence in pursuing solutions to the basic health policies of our Nation.

To date both the public and private sectors have failed to establish any comprehensive plan for dealing with the catastrophic and long-term care needs of the elderly and disabled.

Those who are at risk are all Americans both young and old. As illustrated in a hearing conducted last month by this panel, even personal savings of hundreds of thousands of dollars can be depleted in a matter of months by the staggering costs of catastrophic care.

Under current law Medicare beneficiaries and the public in general are largely uninsured and underinsured against the cost of prolonged care in a hospital, nursing home, or within their own home.

Various proposals have been offered to meet this need ranging from the creation of a part C in Medicare, at least for the aged, to the use of savings accounts to purchase private sector insurance policies for all groups.

Today we are examining the importance of home health care services in the development of a catastrophic and long-term-care package.

It is obvious that any plan for assisting the disabled and aged must also include a provision for adequate home health care. Of the approximately 6½ million senile or disabled persons who need fulltime custodial care, some 5 million are currently cared for in the home.

This dimension of care must be preserved and encouraged as a cost-effective and patient-oriented element of chronic disease treatment. I might add here that, as a smalltown lawyer, I remember so well my clients who were writing wills or trying to deal with the problem of their years in retirement. Often their major concern was that they be able to stay in their home as long as possible.

I think we really do not fully appreciate how important it is to people that there be a program or programs that allow them to stay in the home environment to the greatest extent possible.

This hearing is designed to explore ways of addressing this concern. It seems to me that there are two things uppermost in the minds of our older citizens: One is to keep your driver's license, and the second one is to be able to stay in your own home.

I can speak from experience of my own parents in this respect in both cases. I was very interested in Dr. Marvin Cetron's written comments regarding the popularity of home care.

He stated that in a study conducted by his organization it was found that 85 percent of the population favor insurance plans that encourage the care of the chronically ill at home.

Even more encouraging was the statistic that home care is preferred by 72 percent of the American public over nursing homes.

I was interested in one of the communities that was trying to develop a zoning code that would allow individuals to build a room onto their house where their parents or anyone that they were responsible for could live without violating the zoning code of that particular county.

I thought it was a very enlightened approach. What it also did was to allow them to use the space in the event the person that it was built for was no longer living.

The testimony to be provided by the highly acclaimed panel of witnesses before us will most certainly provide an insight into the problem and how to serve the best interest of the aged.

After much study of this issue, I have joined with other members of this subcommittee in introducing legislation which we feel goes toward addressing this issue. Our distinguished Chairman Pepper has also offered a proposal for dealing with the matter of catastrophic care.

I am confident that we can work together in a bipartisan spirit to find an answer to this great need of our Nation's elderly. Thank you, Mr. Chairman.

STATEMENT OF REPRESENTATIVE RON WYDEN

Mr. WYDEN. I thank my colleague. Just before our witnesses begin, let me make a very brief opening statement. I am particularly concerned about the administration's cutbacks, cutbacks that have been clearly documented by the Association of Home Care in the critically needed benefits.

It seems to me what is particularly discrepant is that these cutbacks are coming at a time when we need home care the most. Because of the new changes in hospital reimbursement, the DRG system, more older people are being released from the hospitals more quickly, and that increases the need for the home care benefits.

So right at the time when other changes in health care reimbursement, specifically with respect to payment, created the greatest need for home care, that is the time the administration goes forward and tries to make these cutbacks, cutbacks that are well documented.

The fact of the matter is that the administration, with all the cutbacks, seems to me to be tearing the roof off the home care benefit. It was a tiny benefit in the first place, and if the cutting continues at its present rate it is going to become almost invisible.

I just think that this is a very sad and unfortunate situation. One of the consequences is that for older people it seems to literally have produced a health care merry-go-round where they just get bumped from one facility to another.

They get released from the hospitals. They go to another program, attempt to get into the Home Care Program, another health

care service, and then end up back in the hospital literally bumped from one facility to another.

I think that is a tragedy, and I hope that we will learn today why the Health Care Financing Administration and the Office of Management and Budget seem to be the only voices in America arguing against an affordable, trustable home care benefit.

I very much look forward to our witnesses and working with colleagues like my good friend from Ohio, Mr. Regula, to see what we can do to turn that situation around.

At this time, I would like to submit the prepared statement of Congressman McCain for the hearing record. Hearing no objections, so ordered.

[The prepared statement of Representative McCain follows:]

PREPARED STATEMENT OF REPRESENTATIVE JOHN MC CAIN

Mr Califano, I appreciate your taking the time to testify before the Subcommittee, and I thank you, Mr. Chairman, for conducting this second hearing on catastrophic health care.

Popular among retirees because of its beneficial climate, Arizona's population contains a large proportion of Older Americans. As a result, the increasingly high cost of health care is of vital concern to me and to my constituents. They and their families are haunted by the fear of having their hard-earned savings suddenly wiped out by a catastrophic illness.

There are a number of proposals that have been put forth with regard to a national catastrophic health care insurance program. Dr. Otis Bowen, Secretary of the Department of Health and Human Services, has suggested that we "beef up" Medicare Part A and Part B, with the increased coverage to be financed by increased beneficiary premiums.

In addition, there are now several legislative plans under consideration. One option is to establish a Medicare Part C, which would cover gaps or coinsurance and provide comprehensive long-term health care services. Medicare Part C would be financed, for the most part, through existing sources of revenue and through a premium to be paid by participants.

Congressman Ralph Regula has developed a second plan, that would allow individuals to voluntarily expand their Medicare coverage to include catastrophic care coverage for an additional monthly fee. It would also allow individuals to establish an Individual Health Services Account (IHSA), similar to an IRA, for health savings.

I am an original co-sponsor of Mr. Regula's bill, which I believe would be less costly than the establishment of Medicare Part C. We must be careful not to institute a program which will need constant overhaul and massive infusions of funds every few years, or which might jeopardize the fiscal stability of the Medicare system.

I believe the inclusion of the private sector in the development of any system of catastrophic health care is essential. The government and the private sector can and should work together to provide insurance to cover these debilitating health care costs. A major failing of many government programs is rigidity and the lack of choice. Flexibility and opportunity are essential. Situations and priorities vary widely and we must institute a system which recognizes this.

Mr. WYDEN. With that we will go right to our witnesses. Our first witness today will be Ms. Randy Kramer from Miami, FL. Why don't we go right to you, Ms. Kramer.

That will be followed by Mr. Peter Fiterman, Ms. Joanne Cooper, Ms. Barbara Oppen, Ms. Connie Fisher, and Mr. Val Halamandaris. Our panel will hold off on any questions until after our witnesses are finished, but let us begin with you, Ms. Kramer, and we welcome you to the subcommittee.

PANEL ONE—VICTIMS OF CATASTROPHIC ILLNESS: CONSISTING OF RANDY KRAMER, CYSTIC FIBROSIS VICTIM, MIAMI, FL; RIVA FITERMAN, ON BEHALF OF HER SON PETER FITERMAN, MOTORCYCLE ACCIDENT VICTIM, CHICAGO, IL; BARBARA OPPER, WIFE OF ALS VICTIM, CHEVY CHASE, MD; CONNIE FISHER, MOTHER OF A CHILD WITH "EDWARD'S SYNDROME", A GENETIC DISORDER, GRAND RAPIDS, MI; JOANNE COOPER, DIABETIC AMPUTEE, AKRON, OH; AND VAL HALAMANDARIS, ESQ., PRESIDENT, NATIONAL ASSOCIATION FOR HOME CARE, WASHINGTON, DC

STATEMENT OF RANDY KRAMER

Ms. KRAMER. Thank you. I have a disease which is not visible to you like muscular dystrophy. Thick mucus builds up in my lungs making it difficult for me to breathe at times. This debilitating disease is called cystic fibrosis. Years ago I would have been confined to the hospital, but now I can fight back, devoting my lifestyle to taking care of my health.

I have become real educated in lung disease and treatment availability; 5 hours out of every day I exercise and take 2 respiratory treatments. These treatments are not a cure-all but survival, and a few hours of relief of not being conscious of every breath I take.

I not only have to deal with the symptoms of my disease. My survival is pitted against bureaucracy like many other disabled victims on Medicare. I am just one person who is speaking for 47 million victims of chronic lung disease.

I am going to try to tell you what we, who have this disease, must do to survive. I am going to try to tell you how the cost of our treatment can be substantially reduced.

I have been eligible for Medicare since I was 22. Medicare pays my doctor bills and hospital bills except for the deductible. I have to see the doctor once a month and I am hospitalized on an average of three to four times a year. Each time I am hospitalized, I stay a minimum of 2 weeks. In addition I go to the hospital twice a day for therapy. I used to have my therapy at home until I reached the \$50,000 limit on my Aetna insurance policy, as the Medicare policy says that in order to receive home care I must be homebound. Even when I am homebound Medicare will only pay for a physical therapist or a skilled nurse. They do not pay for the respiratory therapists who are qualified and trained.

I would also like to mention that last year Governor Graham signed a bill for licensing of a respiratory therapist; 10 States including Florida now have this requirement and the others are pending. Due to this acknowledgment it would be feasible to include a respiratory therapist in the Medicare provisions since they

are more qualified and less expensive to treat a patient rather than a nurse or physical therapist.

Now, this forces me to use the outpatient department of the Baptist Hospital for my treatment. The cost of these treatments is \$190 a day. The cost of the same treatment at home is \$60 a day.

The Government can save a lot of money by letting me get therapy at home. It would be better for me because every time I go to the hospital, I am exposed to sickness that could cause readmission to the hospital. I am burning my Social Security money up on travel, and it is also wear and tear on my body. As you know there is traffic in the morning, and getting up at 6 o'clock in the morning is difficult for me.

I have a new insurance policy is suppose to cover 80 percent of what Medicare does not pay, but this does not cover home care either, plus it has a \$1,000 deductible.

I have written letters to Congressmen and everyone else I can think of. When I get sick, I need help, and I need help from getting sick. I just cannot seem to get through all this redtape.

Limitations on the provision of health care is hurting rather than helping. With all the hard decisions legislators make in light of budgetary constraints, is it not great to think that you can improve our situation and reduce the cost at the same time?

Mr. WYDEN. Thank you very much for an excellent statement, Ms. Kramer. I would like just to say that there are many others out there that are fighting through the redtape, and we want to cut some of this, and look at some ways today. We will have some questions momentarily.

Mr. Peter Fiterman.

Mrs. FITERMAN. Mr. Peter Fiterman is nonverbal, but has all faculties. I am his mother and I am accompanying him.

Mr. WYDEN. We welcome you.

STATEMENT OF RIVA FITERMAN ON BEHALF OF HER SON, PETER FITERMAN

Mrs. FITERMAN. Peter has a disease of the future. It was caused by an injury. He is a person who was involved in a motorcycle accident while attending Tulane University. There are 50,000 new cases like him every year, usually young males under 30.

His accident occurred while attending the University of Tulane in New Orleans. He was then 19 and 3 months, and in his second year of school. We had a \$600,000 medical insurance policy. That money was gone within 13 months. He was first taken care of at Mercy Hospital in New Orleans where he stayed for 3½ weeks and was in a coma. We transported him back to Illinois because of the expense of staying with a child in a city that is not your home was utterly exorbitant. We then entered Billings Hospital in Chicago which was close to our home area. He stayed there for 10 weeks. Each one of the transfers to the hospitals, by the way, was not covered under any insurance. It was out-of-the-pocket family money.

I never dreamed this could happen. We have been devastated. He was then accepted to the rehabilitation center in Chicago which we are most fortunate to have. They seem to work the system better than anybody. I have never learned how to work the system. Peter

was not eligible for any Medicare until 2½ years into this. We were not free funded.

I watched the house that we have lived in for 24 years become encumbered with new debt. We were misfortunate enough to be a family headed by a woman. I never considered myself a charity. We had never been on a roll in our life. When we became eligible for Medicare, we started his rehabilitation surgery because our funds had gone just to save his life. He has since been in the hospital only once, twice for rehabilitation surgery and only once for 4 months. He had major hip surgery.

We live alone, just he and I. He wishes to return to life. He does not plan on staying on these rolls forever. There is only so much. I have watched myself be totally destroyed by being locked in a house with a child who is a fighter. I brought pictures with me. He was once down to 72 pounds. He could not even sit up or hold his head. He was more simple than a newborn infant. Today he is a vital and alive person. He can stand. He can pivot. He can move. He can read a book. He has hopes in going back to school, and without home health care none of this would have been possible. There is a limit to how much a mother can push and tote her child around.

I cannot express to you what home health has meant to us. They taught me how to care for him. Hospital care is one thing. We brought him covered with bed sores, sheet sores, everything. We have come home with drains in our hips when he has his hip done. He had a drain in his hip. There is no way. There is nothing that I can say to express to you what home health has done. There would be no way. My whole day is consumed with him as it is under our own roof. We know other parents, from head-injured parents. The majority of these parents are forced to walk away from their child either because there are younger members of the family and they cannot devote this much time.

They are institutionalized and cost the Government \$50,000, \$60,000 a year. Eventually they die. My son has only gotten healthier and better. I remember we were fortunate in having a Dr. Klein in New Orleans.

He said to me: "You hang in there. It may take 8, it may take 10 years. He will make it. His cortex of his brain was never hurt, and I think it is so important." The last picture in the book that is being passed around is a picture of Peter coming back from one of his surgeries.

Each time it has been go back to square 1, but each time he comes back faster. All of this has been done in our own home except for the first 8½ months that he spent in the hospital for the corrective surgery.

His voice aide, for instance. This is another bill before you, gentlemen, things that help people to talk and communicate. Our Government does not help us. This has cost me \$3,100. It took 2 years to pay for it.

I mean these things are enormous, but it enables him to communicate. At one point he thought he was——

Mr. FITERMAN [speaking from communication equipment]. I want to go back to school.

Mrs. FITERMAN. He wants to go back to school. Also——

Mr. FITERMAN [speaking from communication equipment]. And be someone.

Mrs. FITERMAN [interpretating for her son]. And be someone like you. In short, his plans were to be a lawyer, and he wants to be someone and help the handicapped.

I just want to tell you there are so many things that I do not know how to put into words. Peter is wearing a pair of shoes that do not fit him because our Government has rules stating that you cannot buy shoes to fit the good foot, but fit the disabled foot.

Now, if he goes and falls over because the right shoe is too big because of the brace that he has to wear on the other shoe, now we have a person with no feet. When I could still afford it, I used to buy his shoes and throw one in the waste basket of each pair.

I am no longer in the position. I suddenly realized that we are going down the tubes, and there is no way I can save us. You have put me in the position of what you call the woman that is alone with her child, cannot work.

I have no other thing to do but take care of this boy. First of all, the average person would not have taken the time to get him this well. I have, I don't want him left on the roles of this Government's disabled when I am gone.

[Mrs. Fiterman interpreting for her son.]

He is collecting Social Security not off his father's nor his mother's, but because he was a good, bright, young man and a National Merit runner up, he worked in the summertime from the time he was 15.

He is collecting Social Security based on five summer semesters of work, five quarters in his life instead of collecting off his father's or mine. He gets \$290 a month, and \$155 SSI. That is it.

I do not lie. Until this year I had an income of \$24,000 a year. This year that ceased. There is no other money coming in but his Social Security.

We have remortgaged a house that was nearly paid in full. I have now encumbered it for \$80,000 when I never owed over \$30,000 when it was brand new and we first moved in it. I now have \$80,000 worth of loans against that.

I do not know what else I can say to you except something is wrong in our system that a family can be annihilated from an illness. I cannot make another Peter Fiterman.

This is what I leave to you. He will not be on the rolls of this Government when I am gone. That is all I have to say.

[The prepared statement of Mrs. Fiterman follows:]

PREPARED STATEMENT OF RIVA FITERMAN, PARK FOREST, IL.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

MY NAME IS RIVA FITERMAN. I AM FROM PARK FOREST, ILLINOIS, AND I'M HERE TODAY ACCOMPANYING MY SON, PETER.

PETER IS THE VICTIM OF A TERRIBLE MOTORCYCLE ACCIDENT WHICH OCCURED ON SEPTEMBER 26, 1981 WHILE HE WAS ATTENDING TULANE UNIVERSITY IN NEW ORLEANS. AT THE TIME, PETER WAS 19 YEARS OLD; HE'S 23 NOW AND WILL BE 24 IN JUNE.

THE NIGHT OF HIS ACCIDENT, PETER WAS TAKEN TO A HOSPITAL IN NEW ORLEANS. AFTER THREE AND A HALF WEEKS, HE WAS TRANSFERRED TO BILLINGS HOSPITAL AT THE UNIVERSITY OF CHICAGO. AT THAT TIME, PETER WAS IN A SEMI-COMATOSE STATE. WHILE AT BILLINGS, HE BECAME FULLY CONSCIOUS; HOWEVER, HE HAD LOST ALL SPEECH AND MOTOR SKILLS DUE TO HIS SEVERE CLOSED HEAD INJURY. IN DECEMBER OF 1981, PETER WAS AGAIN TRANSFERRED, THIS TIME TO NORTHWESTERN REHABILITATION HOSPITAL.

ORIGINALLY THESE HOSPITALIZATIONS WERE PAID FOR BY A \$600,000 MAJOR MEDICAL INSURANCE POLICY FOR PETER. BY NOVEMBER OF 1983, THE HOSPITAL BILLS HAD COMPLETELY DEPLETED THIS POLICY. OF COURSE, AT THAT POINT, PETER WAS UNINSURABLE. HE HAD NOT BEEN DISABLED FOR TWO AND ONE HALF YEARS AND WAS THEREFORE NOT ENTITLED TO MEDICARE. FORTUNATELY, HE HAD TURNED 21 IN JUNE OF 1983, SO HE WAS ENTITLED TO MEDICAID, WHICH WAS OF SOME HELP. HOWEVER, THE SMALL AMOUNT OF MONEY RECEIVED DID NOT AND DOES NOT PAY FOR THE SPECIAL SHOES PETER MUST HAVE, THE DURABLE MEDICAL EQUIPMENT, OR THE SPECIAL TRANSPORTATION NEEDED. BY 1983, I HAD TO REMORTGAGE MY HOUSE, WHICH HAD BEEN PAID FOR SINCE 1982, IN ORDER TO COVER THESE COSTS. I AM IN THE PROCESS OF HAVING TO TAKE OUT A SECOND MORTGAGE TO COVER MORE MEDICAL COSTS.

IN AUGUST, 1983, PETER HAD SURGERY FOR A FRONTAL SHUNT. IN NOVEMBER, 1983, HE HAD THE ECTOPIC BONE IN HIS HIP REMOVED. HIS LEG HAD TURNED INWARD, SO SURGERY WAS DONE TO STRAIGHTEN THE LEG. HE ALSO HAD SURGERY ON HIS ARM, WHICH PROVED UNSUCCESSFUL BECAUSE IT NECESSITATED THERAPY USING GRAVITY CAUSED BY STANDING. BECAUSE OF HIS SURGERY AND THE CAST ON HIS LEG, PETER COULDN'T STAND.

THIS HOSPITALIZATION LASTED TWELVE WEEKS. WITHIN THREE DAYS OF HOSPITAL DISCHARGE, PETER HAD PULMONARY ARREST. HE WAS RUSHED TO THE NEAREST

HOSPITAL, WHERE HE STAYED FOR TWO DAYS. FIFTEEN HOURS AFTER DISCHARGE, HE HAD PULMONARY ARREST AGAIN. BECAUSE OF THE INADEQUACY OF CARE AT THE NEARBY HOSPITAL, MY DAUGHTER AND I PUT PETER IN OUR VAN WITH I.V. BOTTLES AND DROVE HIM TO ANOTHER HOSPITAL, APPROXIMATELY 45 MINUTES FROM OUR HOUSE. PETER REMAINED THERE FOR TWO TO THREE WEEKS. WHEN HE LEFT THE HOSPITAL HE HAD DECUBITI THE SIZE OF FISTS AT ALL PRESSURE POINTS AND HE HAD A DRAINAGE IN HIS HIP. HE WAS STILL UNABLE TO SPEAK; HOWEVER, PHYSICAL THERAPY HAD BEGUN.

THANKS TO A FRIEND, WE DISCOVERED MONEE HOME HEALTH CARE, WHICH HAS GIVEN PETER THE CAPABILITY TO FIND A PLACE IN THIS LIFE. MONEE HOME HEALTH CARE GAVE US NURSES TO CLEAR PETER'S SKIN, WHICH THEY DID SUCCESSFULLY; A PHYSICAL THERAPIST WHO BROUGHT HIM FROM A STATE OF TOTAL DEPENDENCE TO USE OF A WHEELCHAIR AND A QUAD CANE; A SPEECH THERAPIST WHO HAS MADE IT POSSIBLE FOR PETER TO USE A PALATAL LIFT; A COMMUNICATION EXPERT TO ENABLE HIM TO USE A COMMUNICATION BOARD AND A VOICE AID; AND AN OCCUPATIONAL THERAPIST TO TEACH PETER TO COPE, WITH MINIMAL ASSISTANCE, WITH ALL OF HIS DAILY LIVING ACTIVITIES. ALL HAVE WORKED SUCCESSFULLY WITH PETER.

WHEN I LEARNED OF PETER'S ACCIDENT, I WAS TOLD HE WAS DEAD. TO SEE THE PROGRESS HE HAS MADE IS TO WITNESS A TRUE MIRACLE. AND PETER CONTINUES TO IMPROVE THROUGH THE DEDICATION AND EFFORTS OF HIS THERAPISTS.

HE WAS GIVEN A MEDICARE CARD IN APRIL OF 1984. THERE IS NO MORE MONEY FOR TRANSPORTATION. WE HAD PURCHASED A SPECIALLY EQUIPPED VAN FOR PETER, BUT WE HAD TO SELL IT FOR THE MONEY. PETER MUST NOW RELY ON A MEDICAR TO MEET HIS DOCTOR APPOINTMENTS. WE HAVE HAD TO PAY FOR HIS \$190 SHOES. WE HAVE HAD TO PAY FOR HIS \$3,500 COMMUNICATION SYSTEM BECAUSE HIS WORDS ARE STILL UNINTELLIGIBLE. WE HAVE HAD TO PAY FOR HIS WHEELCHAIR, HIS BATHROOM EQUIPMENT, SHOWER CHAIRS AND TOILET SEATS. WE HAVE HAD TO PAY FOR HIS CANES AND FOR MAINTENANCE ON HIS WHEELCHAIR, WHICH IS FREQUENT GIVEN THE AMOUNT OF USAGE. WE ARE LOOKING FORWARD TO HAVING THE SURGERY ON HIS ARM PERFORMED AGAIN LATER THIS YEAR.

MONEE HOME HEALTH CARE HAS LITERALLY KEPT PETER FROM DAILY TRIPS TO OR CONFINEMENT IN A HOSPITAL. IF YOU TAKE AWAY THESE PRIVILEGES, YOU WILL LEAVE MY CHILD WITHOUT A PLACE IN SOCIETY.

THANK YOU.

Mr. WYDEN. Well, Mrs. Fiterman, let me just say before we go on how much we admire the courage of you and your son, and how exceptional an effort we know it has been to be here and to help your boy come and make all the progress he has.

I just want you to know that is why we are having this hearing to build a record so we can get rid of these stupid arbitrary Government policies that are hampering our citizens from being able to attain their potential.

Because you are here and you made such a compelling case, the job is going to be a little bit easier now.

Mrs. FITERMAN. Thank you.

Mr. WYDEN. Mrs. Barbara Oppen from Chevy Chase, MD, we welcome you.

STATEMENT OF BARBARA OPPER

Mrs. OPPER. Thank you. Fifteen years ago as a Federal Government employee, I was given the choice of selecting a new major medical health insurance plan. This covered nearly all physician, prescription drug, and hospital costs, but it was limited to a lifetime maximum of \$100,000.

I felt that turned the principle of insurance on its head because it seemed to be missing the catastrophic coverage. So I called a friend, an actuary, to see if he knew of any catastrophic insurance policies being written. He did and I purchased the coverage. Before any benefits could be paid a very large deductible had to be satisfied by expenses incurred for a single illness within a specified period of time. Our deductible was \$10,000, the qualifying period 18 months.

Then in 1981 my husband, 41 years old at the time, retired on a U.S. Civil Service disability pension. He had amyotrophic lateral sclerosis or ALS. ALS is also known as Lou Gehrig's disease. It leaves the intellect unimpaired, but it progressively robs its victims of their voluntary muscle use by interfering with the nerve impulses that control such movement.

At the time he retired my husband already had lost his ability to walk and only little use of his arms and hands remained. He soon became a quadriplegic, and in 1983 he lost his ability to eat and speak. He has communicated since then using the only voluntary movement remaining to him, blinking his eyes. Clearly a person in that condition cannot be left alone.

Most health insurance plans exempt themselves from what they call custodial care. Custodial care loosely is the kind given when there is no hope of improving the patient's health. Accordingly, of all the seemingly excellent insurance plans available to us as Federal Government employees, the best of these limited home nursing coverage for my husband to 2 hours a day. This left us uncovered for 22 hours a day.

After satisfying the qualifying deductible on our private catastrophic health insurance, we saw that 10 years of inflation had taken its toll. Our policy would only pay about one-fourth of today's prevailing nursing rates. As a family with seemingly full health insurance protection we were faced with a selection among horrors. It was unacceptable to leave my husband at home unat-

tended. In the hours that I was not at the office I provided the nursing care he needed while I also cared for our two young children. I did this for nearly 2 years. Finally, choosing between physical exhaustion and financial ruin I hired nurses. That left my family shouldering most of the expenses for 22 hours a day with nursing rates ranging upward from \$12 an hour. Each week we required help for 154 hours. That time multiplied by \$10 even just to make the arithmetic easy, times 52 weeks, adds up to \$80,000 for 1 year.

Ironically not a penny of those costs would have been ours to bear if my husband had been hospitalized, cared for by hospital staff nurses. Our excellent health insurance would have borne all those institutional expenses. The total cost would have been much higher, and he would have occupied a hospital bed unnecessarily, but had we responded to the incentives built into the system that would have been our course.

I wanted to keep my husband at home as long as possible so that we could preserve our family, and so he could at least enjoy a familiar and comforting setting while coping with his illness.

Our unfortunate experience illustrates needs that should be met. It also illustrates a misfocus by both purchasers and providers of health insurance on first dollar medical expenses as against the open-ended expenses. That misfocus alone, I think, is part of the reason the American public is facing escalating medical costs, escalating health insurance costs, and, even so, escalating exposure to the expenses of catastrophic illness.

I am pleased to be able to be here today. Perhaps my statement will do some good and bring about reform so that others will not have to endure what my family has.

Speaking as I am for my family and those many others in similar circumstances, I can tell you that catastrophic illness is catastrophic in many dimensions, but in this country there is no need for one of those dimensions to be financial. Thank you.

Mr. WYDEN. Thank you for an excellent presentation, Mrs. Oppen. I looked at your case, and it seems to me to illustrate a major kind of flaw in what we offer today in health care, is you have to be very sick to get coverage, but if you are too sick you do not get coverage again.

Mrs. OPPER. That is right.

Mr. WYDEN. Literally millions fall between the cracks.

Mrs. OPPER. That is right.

Mr. WYDEN. And we thank you for a very, very fine presentation. Our next witness, Mrs. Connie Fisher from Grand Rapids, MI. We welcome you, Mrs. Fisher.

STATEMENT OF CONNIE FISCHER

Mrs. FISCHER. Thank you. Good morning. My family and I would like to thank you for this chance to appear here today and tell you the story of our daughter Katherine. It is not an easy story to relate, but I feel that I must. The situation our family faces with Katherine is a personal one, but it is not unique to the Fischers of Grand Rapids. We are but one example of what happens when both

Government programs and private insurance fail to provide adequately for alternatives to institutional care.

First, let me tell you a little bit about our Katherine. She is 16 years old and the youngest of our six children. She was born with a chromosome abnormality called trisomy 18. Kath does not hear or speak or turn over in her bed. She suffers from heart, kidney, and intestinal ailments and is prone to seizures. Obviously, she requires long-term catastrophic care, and her recurring deteriorating heart failure demands constant skilled nursing assessment.

I must share with you that we love her a lot. We also have a very deep desire for her to die at home. I want to make it clear that for all of her medical difficulties, Katherine is as much a part of our family as my husband, myself, or any of our other children.

That fact which seems so simple and so obvious to me underlies the problems we are facing. You see we want Katherine to be at home. She belongs at home. A hospital is an inappropriate placement for her because hospitals exist to make people well, and Katherine is never going to be well.

We do not know how much time we will have with her. So what time there is is very precious. To me it is inexcusable that some very fundamental rights, mainly Katherine's rights to be at home and our right to choose that alternative for her are seriously jeopardized by an inadequate and unjust reimbursement system.

My husband Chuck has worked for the U.S. Postal Service for 37 years. Our health insurance is obtained through his employer. Since 1976 we have had the Postmasters Benefit Plan which is underwritten by Prudential. In our view it was the most comprehensive plan available to us. It covers up to 364 days per year for care in an acute care facility or an extended care facility. Prior to 1983 the Plan also covered the majority of expenses incurred for home care. Specifically the plan paid for 80 percent of the cost incurred up to the first \$10,000 and 100 percent of amounts in excess of \$10,000.

In 1983 the Plan changed its benefits for private duty nursing in the home by placing a \$10,000 yearly cap on benefits. The benefits for institutional care did not change. Along with other insured families we received a 1-year waiver on imposition of the \$10,000 limit, but it went into effect again in 1984.

Until the time of the change we had handled Katherine's care ourselves because we wanted to do so, and we were able to do so. But then just as we reached a point where we needed to invoke the benefits of our insurance plan, the plan was changed. Katherine's medical condition worsened that year, and she was hospitalized twice in the fall of 1983. Her second hospitalization lasted 6 weeks, and she was discharged on Christmas Eve as a hospice patient.

At that time Katherine's doctor did not expect her to live more than a few months. We wanted to keep her at home, but her weakened condition demanded more care than Chuck and I could provide alone. After all those years when we did not use the benefits available for us, now when we really needed them we had a \$10,000 cap to contend with. The money was gone with frugal management by early May, and it lasted that long only because we provided virtually all of the care ourselves. We received 150 hours of crisis intervention nursing from the Michigan Crippled Children's Pro-

gram, but that expired the first week of June. We applied for a waiver under the special targeted Model Home and Community Based Waiver, but we were turned down by the Michigan Department of Social Services. We were told we were not entitled to the waiver because Kath was not Medicaid eligible and because the cost of home care was not less expensive to the State than alternate institutional care since our insurance would have covered all of that.

In July 1984 we had to give up and temporarily rehospitalize our daughter because the strain placed on us of providing 24-hour care was compromising her medical condition. We did not want to put her back in an institution but we had no choice. In the meantime we requested support from every agency and every public official available. We were finally able to get Kath back home through special arrangements and funding provided by the Michigan Department of Mental Health. Even that help would not have been available to us, but for the fact that Katherine is severely retarded.

In 1985 we applied for the State's new mental health waiver, and we have done so again in this year although that total allotment is just shortly over \$19,000. That would only be a partial solution if it is granted, but it would help. Meanwhile we try to conserve every nickel of our \$10,000 in insurance benefits. We have asked Postmaster's to waive their limit on home care benefits. In fact, Mr. Chairman, you have made that same request on our behalf and we thank you. We can certainly provide Katherine with care at home for less than what a hospital or skilled nursing facility would cost, but that is really not the point. Katherine belongs at home. That is not a dollars and cents issue. It is a very human issue, and a very simple fact.

We meet with roadblocks everywhere we turn. We do not qualify for Medicare because Katherine needs more than intermittent care. We do not qualify for Medicaid because of our income level. Our insurance will pay for Katherine's care, but only if we relinquish our right to keep her at home. We have even asked the White House for assistance and have not had an answer to a letter which we had sent 6 months ago. We are hopeful we will qualify again for the mental health waiver, but even if that comes through, there is a fundamental issue here that is being ignored. Our ability, and our right, to have our daughter at home should not be determined by her IQ. It should not even be determined by comparative costs although that comparison clearly favors home care. In fact at the time of Katherine's last hospitalization the daily cost was \$392.55 per day not including ancillary expenses. Her daily rate in the intensive care unit was \$725 per day, room and board only. By contrast our budget for home care nursing could be \$200 per day, and what should be determinative is what environment is more suitable for Katherine based on her medical needs and prognosis.

We are not the only family in this situation. Not long ago I heard the chairman of the board of Prudential say on television that the future belongs to those who prepared for it. We feel we prepared for her future. We did everything we could to prepare financially, but neither the government programs nor our private insurance is sufficient. We should have the option of our daughter at

home. That may not be the solution for every family. Each case should be examined, and the interests of the patient and the patient's family should be paramount.

That seems to be the right thing to do, and if it is, I wonder why we are not doing it. Thank you very much.

Mr. PEPPER. Thank you very much, Mrs. Fischer, for your excellent statement. Our next witness is Mrs. Joanne Cooper, a diabetic amputee from Akron, Ohio, who is accompanied by Mrs. Sue Brempekemp, a visiting nurse. We will be glad to have you proceed, Mrs. Cooper.

STATEMENT OF JOANNE COOPER

Ms. COOPER. Thank you. Mr. Chairman, and members of the committee, my name is Joanne Cooper, and I am from Akron, OH. I am here today to share with you the experience I have had as a home health patient. I am speaking not only for myself, but for the millions of other Americans who today find themselves caught in a system that often seems to overlook the plight of the individual.

I am a diabetic. This condition caused renal failure, and I must have dialysis treatment three times per week. In January 1985, I had surgery to place a fistula in my right arm for dialysis treatments. After the surgery I developed reduced functions of my right arm and movement of my fingers and thumb was impaired. While in the hospital, I also suffered a stroke which caused further weakness in my right arm. In addition to the renal failure, the diabetes has caused retinopathy leaving me legally blind.

When I was discharged from the hospital in January of 1985 I was very weak. I required help with all of the daily necessities of living including bathing, dressing, transferring, and meal preparation. I was referred to the visiting nurse service at this time. Physical therapists and occupational therapists worked with me to help me regain my dexterity and strength. The therapy was successful in that I can now walk several feet using a walker. Nursing visits were ordered to make sure that a capable person was giving me daily insulin shots. Home health aides visited to help with my personal care. Reimbursements for these necessities from health visits were subsequently denied by the fiscal intermediary on the basis that I am not homebound.

The determination of my homebound status did not seem justified. I only leave my home three times a week for my dialysis treatments. This is a life-saving procedure, not a leisure time activity.

In order to get to the dialysis center, I require assistance with dressing and getting into the wheelchair. It takes two people to take me down the outside ramp and into the special SCAT transportation van that is used to take me to the treatment center. Dialysis is a lengthy and grueling affair. I am exhausted and feel light-headed after each treatment. My days in between treatments are spent resting and recuperating.

Following the denial I requested a reevaluation. I have recently been notified that the visits of the physical and occupational therapists will be paid. However, a denial of the nursing and home health aides visits would not be revised because my diabetic condi-

tion existed for many years. What the fiscal intermediary is ignoring is that the fact that before my January 1985 hospitalization, I was independent in insulin administration. After the surgery, I was not able to self-administer the insulin, and nursing visits were necessary to instruct the caregiver in proper administration.

All I ask is that the system recognize the existing inequities and make the necessary changes so that the millions of people in situations similar to mine have the opportunity to do more than just exist.

Thank you.

Mr. PEPPER. Well, thank you for a moving statement. If I were on the board, I would decide with you.

Ms. COOPER. Thank you, Mr. Chairman.

Mr. PEPPER. Our last witness on the panel is a very distinguished advocate of greater home care for the people of this country.

He has extraordinary experience as a member of the staff of the Senate Select Committee on Aging and the House Select Committee on Aging while I was chairman. He is eminently qualified in this very critical field, and now serves as the distinguished president of the National Association for Home Care in Washington, Mr. Val Halamandaris.

STATEMENT OF VAL HALAMANDARIS

Mr. HALAMANDARIS. Thank you, Mr. Chairman and members of the committee. It is a privilege for me to be back here visiting with you, and I greatly admire the work that you do on a daily basis.

I am not going to make a prepared, formal statement, but I would like to transmit to this committee the report that we have prepared entitled, "The Attempted Dismantling of the Medicare Home Benefit." We are transmitting this report to you in order that you might analyze and perhaps enter it in the record, Mr. Chairman.

Mr. PEPPER. Mr. Val Halamandaris, we are delighted to have this distinguished report from your eminent committee. It contains invaluable information and will be of great help to those concerned about this great subject.

So we accept this report with our thanks and highly commend you and your organization, and I hereby release it for publication at the present time. Thank you very much.

[The report, "The Attempted Dismantling of the Medicare Home Care Benefit," dated April, 1986, is available on a limited basis from the Subcommittee on Health and Long-Term Care.]

Mr. HALAMANDARIS. Thank you, Mr. Chairman. We appreciate that very much. The reason that we prepared a report is it would probably take me 2 or 3 hours to describe the numerous steps that have been taken to dismantle the current Medicare home care benefit.

All of us here today have the hope and the expectation that we can broaden the scope of the current Medicare coverage to those people who are in need, but you see around us at the table representatives of 32 million Americans.

One out of every seven Americans today is in need of home health care. One out of every seven Americans needs care and yet only about two million Americans benefit at the present time.

So there is a tremendous need. You talk about catastrophic health protection. This is the group that is in the greatest need, and yet unfortunately what we have done is to cut back on the level of reimbursement that we have given to care for these people.

It is a rather cruel irony, and I wanted to describe this to you in some way that would stay with you that would perhaps distill it all. So if you will stay with me, I would like to draw you a brief diagram.

In order to qualify for the Medicare Home Care Benefit, first an individual has to be sick enough to qualify for skilled nursing care, and I want you to imagine in your mind a box because that is what I am going to draw.

The left-hand side of the box and individual must be sick enough to meet that test of skilled nursing care. The particular nursing arts have to be such that you meet the test of skilled nursing. You have to be sick enough.

The right-hand side of the box is that you cannot be too sick. If you are too sick, you are excluded from care because you do not meet intermittent tests that is in the statute.

The bottom of the box is that you have to be homebound. You have to be restricted to your home. Now, the top part of the box, Mr. Chairman, is that the care has to be reasonable and necessary and ordered by a physician.

Now, what has happened is that this administration has moved the four sides of that box closer and closer together by administrative action to the point that it now resembles an Alfred Hitchcock elevator.

The four sides are coming closer and closer together. At the same time we have increased the number of people that have been pushed into that box into home care by 37 percent.

Now, this is not yours truly or the national association speaking or some group with vested interests. This is the finding of the General Accounting Office as given to your sister committee, the Senate Aging Committee.

We have a 37-percent increase in the number of people going into home care since the enacted of DRG's which is to say in the last 2 years. At the same time we pushed the sides of this together so that more and more people are going without the coverage that they need.

Now, I would like to give you a couple of illustrations of people that they now say are outside of that box, but I want you to keep in mind how the system operates.

From the point of view of the person running a home health agency individuals who need care are presented on their doorstep. Anyone with humanity will care for these people rather than turn them away.

Unfortunately what happens later on is reimbursement comes after the fact. The insurance companies which administer Medicare find seemingly millions and millions of reasons for denying that the care that was given was reimburseable.

That is the cruel, cruel fact here. Now, most of them are denied for one of these four reasons, but believe me the insurance companies that administer Medicare have thousands of other reasons that they use for denying reimbursement.

I would like to give you a couple of illustrations of the kind of care that is denied, and you have heard some of that today. First, with respect to not meeting the skilled care, in other words you are not sick enough.

They said that a 65-year-old diabetic person that had an ulcer on their toe did not need skilled care on a daily basis. So that rejected the efforts of the home health agency to care for them for more than a couple of visits.

The end result was that that individual developed gangrene on that toe, and then three days later was in the hospital and had his entire leg amputated. Now, the cost to the Government was staggering.

Nevertheless somebody in the insurance industry decided that person was not sick enough to qualify for skilled care.

Mr. PEPPER. Excuse me. They ought to cut off a part of the leg of the one who denied him.

Mr. HALAMANDARIS. Another example, Mr. Chairman, that is in the report involves an elderly gentleman who developed a malignant sarcoma on the hip. It is a kind of cancer, and it developed a hole in this person's hip that was 4 inches by 5 inches, a deep wound if you will that was cancerous and growing and spreading.

Some genius in the Department of Health and Human Services decided that that was not—that did not qualify. The person was not sick enough to merit home care. So they denied the care that was offered, and predictably the individual became much worse; then was put in the hospital, and then we paid for it at that point, but it was too late of course. The individual died, and Medicare paid many times what they would have paid if that ounce of prevention, if home care was allowed.

So they have to be sick enough. Now, let me give you some examples of care that was denied because they said, hey, you are too sick to qualify for home care. The Medicare benefit never contemplated caring for people who ought to be in the nursing home.

The cruel irony here is of course Medicare pays for no nursing home care. So that what they are really saying that they are washing their hands with the particular patients.

Examples, there is an individual in New Jersey, and this is an outrageous example, Mr. Chairman, if you will bear with me. An individual who was a Vietnam veteran, huge man, weighed about 300 pounds in his forties, and he developed a brain tumor.

As those things go, very, very rapidly it progressed to the point where most of his faculties left. He was hospitalized at Sloane Kettering. He was in that hospital for several months.

Finally, the hospital made the determination that chemotherapy, nothing would help. He had developed massive bed sores all over his body, on his heels, on his buttocks, and again a huge man.

They discharged him into the custody of a home health agency in New Jersey. The home health agency began to tender care when the Government first came along and said you are not sick enough. Bed sores, hell, anybody can deal with bed sores.

Some physician hit the roof and ultimately it was decided that indeed he was sick enough to meet the skilled nursing test that I just talked about. They began to offer the care, and in tending to these wounds the bed sores were healing.

Unfortunately the insurance companies decided that he was not sick enough, and they denied all care retroactive to the beginning date. In other words they denied 6 months' worth of care on this particular individual.

Now, I want you to understand the background so that you know here. The individual who was in his forties as I said a Vietnam vet was discharged to his home where his frail mother of 75 was trying to care for him.

You can imagine the difficulty of the woman trying to care for these huge bed sores herself. It took two nurses to care for him, to turn him and to meet his needs because he was so heavy, and at the same time he was in such pain that when you touched his flesh, he would literally flinch.

The woman, his mother, was taking care of her husband who was in his eighties and had recently had a stroke simultaneously, and she was caring for the husband's mother who was living with her at the same time.

Imagine the burden on this woman of trying to care for these three people at the same time. The Government in its wisdom decided that the individual was not sick enough to meet the intermittent test.

In other words the individual then was too sick. They told the home health agency, you should have known from the beginning that this person was too sick to meet the intermittent test.

In other words if you fell outside of this box, then you should have known it. So all care was denied going to the beginning date.

The denial came in July of 1985, and they denied care back to October when the individual was first admitted into home care service. While needless to say we intervened in that case, and the money was ultimately allowed. The payment was allowed.

That was down the road. The problem was solved much earlier by this 40-year-old quadraplegic, paraplegic, I am sorry, Vietnam vet, with a .38 pistol. He committed suicide, Mr. Chairman. He solved everybody's problems.

I would like to give you a couple of examples now of the bottom of the box where I said, you know care is denied because individuals are not thought to be homebound. The lady on my extreme left just said that her care was denied because she is homebound.

But what does it mean to be homebound. In the statute it simply says that people can qualify for care if they need help in leaving their homes. If you need the help of a wheelchair or the walker or some third party to leave your home, you still qualify for care.

But increasingly as I said, the sides of this box are coming closer together, and defining that more and more to equal bedbound. If you are bedbound, you might qualify for care.

All right, a person with lung cancer and metastasis, a severe problem, made the mistake of leaving his home to go to the corner drug store. The insurance company came along and said if you are well enough to walk down to the drug store by yourself, you are not homebound.

You do not qualify. We are not going to pay for your care. Another extreme case in the Indian reservation, among the Navajos out in Arizona, they have a custom that if mother or father or grandfather dies in your home, you have got to burn the house down.

You cannot allow anybody to die in your home. The evil spirits will come out. So when somebody becomes on the threshold of death, they move them outside their home into a teepee or on a mattress on the back of a flatbed truck or whatever it is.

They moved the individuals outside of their home. This is an actual case where a person was on the verge of death, and the Indian family—he needed home care obviously and an Indian family moved the person outside the home 50 feet from the home.

They continued to care for the individual. The Government said hey, you are not homebound. We are not going to pay for this care.

There is an old man in Idaho, Mr. Chairman, who was in his eighties who lives in a cabin; no telephone, no neighbors. The only way he communicates with the public is by shooting a rifle. He shoots a rifle when he gets in trouble.

Unfortunately he has the bad habit of walking into his outdoor privy, and that has excluded him from coverage because he is not homebound. Now, if you can imagine the ridiculous state that we are in.

Now, the top of the box, people are being excluded because it is not reasonable and necessary. A couple of illustrations to make that point.

There are physicians who will tell you that IV chemotherapy is much better at home because an individual in his home environment is a good deal more comfortable. There are high cure rates associated with it.

The young lady on my left told you the trauma of having to leave home and get her therapy in the hospital every day. So studies now have documented that IV chemotherapy which is to say given intravenously is much more effective in curing cancer when it is given in the home than when it is in the hospital which is to say nothing of the fact that it is much better for the patients involved, a good deal less trauma.

Unfortunately our Government will not allow for home care to be paid for and have IV chemotherapy given at home. They have just determined that that is something they should not pay.

Similarly if you have a serious infection, a bone infection of some kind which necessitates your being given massive infusions of antibiotics in the veins which is to say IV antibiotics, care that has been given to individuals like that is denied because it is not reasonable.

Now, I would pose it to you, Mr. Chairman, that these are the very kinds of care that are indeed reasonable which are necessary. They are all ordered by physicians, and we should be paying for them.

The fact that we are not paying for them necessitates in the individuals being placed in the hospital and many, many, many times the cost.

Now, I would like to just give a couple of the major findings of our report, Mr. Chairman, to wrap up so that you understand, and

first understand that our report is based on questionnaires that we sent to every home health agency in the Nation.

It is important because home health agencies are the safety net that we, all of us put underneath to catch people coming out of hospitals. Nobody in Congress voted to establish that perspective DRG system with the thought we are going to dump people.

The idea is that we can move people out of hospitals into less expensive levels of care. The idea is now that we have saved billions of dollars by moving people out of hospitals earlier that we should allocate some few nickels or some few millions of dollars to take care of those individuals at home.

What this Government has done unfortunately is to try to trim the candle at both ends. Having saved billions of dollars by moving people out of the hospital early, we have failed to expand even by a small amount the dollars to pay for home care.

As a matter of fact, we are actually contracting on the level of home care services, and back to my analogy, the four walls of the home care benefit are being pushed closer and closer together at the same time when we have increased the number of people going into that box by 37 percent.

It is a totally untenable position, Mr. Chairman, and our report, the major findings of which first of all that millions of older Americans are going without the health care services they need.

Some 75 percent of those who responded to our questionnaire indicated that there were massive numbers of people in their communities who were going without the care and services they need.

Second, the gaps in the American health care system have been widening. Third, that DRG's had the direct effect of making it impossible for many Americans to receive the care that they need.

Some 92 percent of the agencies that we questioned responded in the affirmative when we asked them has DRG's made the system worse, are there more people falling between the cracks, and they responded affirmatively.

Our studies prove conclusively that DRG's have saved billions of dollars. We have reduced the average length of stay that Medicare is paying for by over 2 days for every Medicare beneficiary.

We have saved billions of dollars and at the same time, we have increasingly proved or found ineligible people who need home health care. The answer is, Mr. Chairman, your amendment in 1981 with Mr. Regula and others that sought to take the lid off of this box has been effectively defeated by the application of the intermittent care benefit where they are saying, we are not going to pay for anybody who is too sick.

That is the one that is pernicious out of all of them. You might have established some reasonable threshold about who qualifies for care. Skilled nursing to me makes a certain amount of sense.

The homebound requirement also makes a certain amount of sense if it is reasonably enforced. If we mean by homebound that we do not want to pay for care for people who are ambulatory, who can get around and so forth, indeed we ought to pay for people who are truly homebound. That makes a certain amount of sense.

To say that care is reasonable makes a certain amount of sense, but to say that we are not going to pay for you because you are too

sick does not make sense to me. It does not make any sense at all, and that is what is being used to defeat your amendment.

The amendment that you, Congressman Wyden, and others pushed through that said that you did not have to be in the hospital 3 days in order to qualify for home care. The number of visits were previously limited to 100 visits, and that was removed by your amendment.

Nobody gets 100 visits now, Mr. Chairman, not even close to 100 visits by a home health agency. The noose has been tightened around the necks of the Medicare beneficiaries to the point that home care virtually does not exist.

I am not exaggerating, Mr. Chairman. The home care benefit is very close to extinction and unless you and this committee move in to save the Medicare benefit, there will not be anything left. There will not be anything left to build upon.

I think it is particularly important that we make this case to you because this committee has had more to do with creating the home care benefit than any committee. You have had five major reports that you have issued including this one about the need to expand the scope of home care.

Congressman Regula has introduced some legislation that I think is absolutely vital that will help families care for their elderly people at home, that would give them tax benefits for caring at home for those people that care for them.

No issue is so much involved, so integral to the House Committee on Aging than home health care. You and I remember, Mr. Chairman, as does Congressman Wyden and Mr. Regula, the reaction to nursing home abuses which created all that publicity that was attendant thereto, that galvanized the support of the Members of Congress that there should be in the House a House Aging Committee similar to the Senate Aging Committee that was doing such fantastic work in that area.

The solution to the answer, not for everyone, but for many people, is home health care. This committee has had more hearings on home health care. The first five hearings that you held in this committee were on home health care.

You have had more committee hearings on home health care than any other subject. There is no issue with which you are greater identified, Mr. Chairman, other than mandatory retirement and Social Security than home health care.

It is something that is central to this committee. It is something that is central to not only the older people in this country, but to 31 million Americans. There are at the present time 10 million children who are in hospitals day in and day out who could be cared for at home.

You heard Connie talk about that. Children whose only playmates are other sick kids and doctors who lived in rooms without windows, without any help at all, the technology has been changed to the point that they could be cared for at home for a fraction of what we are spending to keep them in the hospital.

There are millions of disabled individuals like the young man on my right who have been in accidents who could be cared for at home at a fraction of the cost of storing them in institutions or

simply ignoring or abandoning them, and the cost to society is massive.

When is America going to wake up? When will America see that we have at our fingertips the solution for a problem that has haunted all of us, the solution of catastrophic health protection based on home health care.

It is time that we faced the fact that we have got to do something about the problem, Mr. Chairman, and unless this committee intervenes, the small, tiny, Medicare Home Care Benefit that we have had that has helped so many people is close to extinction.

[See appendix for an excerpt of "The Attempted Dismantling of the Medicare Home Health Benefit," a report prepared by the National Association for Home Care for Chairman Claude Pepper.]

Mr. PEPPER. Mr. Val Halamandaris, thank you very much for your very able statement. Do you consider that the interpretation being placed upon the law relative to home care as contained in Medicare legislation is accurate, is within the scope of the intention of the Congress when that legislation was enacted?

Mr. HALAMANDARIS. No, sir, it is not. It is completely out of synch with the intention of Congress. What has happened is documented in this report so well is a series of small administrative changes that have been made under the guise that they are not substantive.

These changes are a lot like being nibbled to death by geese. Each and of themselves they do not look like much, but when you add them up, the accumulation is to undercut the existing Medicare benefit.

It also, and Senator Durenberger said it better than I did. He talked about the Department of Health and Human Services and our Republican Senator from Minnesota. He said that HHS has crossed the line between policy making and policy implementation.

What they are doing is stealing the prerogative of the Congress. Now, it is your prerogative, Mr. Chairman, and the Members of the Congress. If you want to wipe out the Medicare home care benefit altogether, that is your authority.

It is your job to do that. If you want to eliminate Medicare, Congress has the authority to do it not the Department. The Department—

Mr. PEPPER. Do you think it desirable that the Congress amend the legislation now on the statute books relative to home care so as to make it clearer?

Mr. HALAMANDARIS. Yes, sir, I do.

Mr. PEPPER. What the congressional intent is?

Mr. HALAMANDARIS. I do, sir.

Mr. PEPPER. Will you give us a draft that you would recommend for the amended law?

Mr. HALAMANDARIS. Yes, sir, we would be delighted, sir.

Mr. PEPPER. Now, are there any questions of the panel? Mr. Wyden?

Mr. WYDEN. Thank you very much, Mr. Chairman. I just think it is outrageous that Ms. Cooper who has told us in her testimony that she is blind, diabetic, an amputee and obviously wheelchair bound is not considered eligible for home care.

I think the first thing that might be appropriate, Mr. Chairman, under your leadership perhaps the committee could intervene on her behalf with the fiscal intermediary to get her eligible.

Mr. PEPPER. Would the gentleman yield?

Mr. WYDEN. I would be happy to.

Mr. PEPPER. One possibility would be for us to send a copy of this hearing to Health and Human Services and respectfully call their attention to the testimony here today—say that we agree with it 100 percent, and ask if they will not change administratively their interpretation. To take the word, homebound, what do you mean by homebound?

Does it mean that anybody can never get out of a home, or a person cannot reasonably get out without a great deal of help or inconvenience, some expense and all that sort of thing?

So, With "housebound" and other the other words, in the regulations, we could advise them what our intentions are. What we believe the congressional intent was. Then if they do not make any administrative changes, why then we will try our best to amend the legislation.

I agree with you. You take the lead, and we will take it up with Ms. Cooper's case.

Mr. WYDEN. Thank you. I think that suggestion is very helpful, Senator, and perhaps Ms. Cooper's case could be a test where we would walk it all the way through the system as an example.

Mr. HALAMANDARIS, if I might, it seems to me what you have described essentially as far as the home care benefit is death by a thousand cuts.

Mr. HALAMANDARIS. Yes, sir.

Mr. WYDEN. Is that a fair description?

Mr. HALAMANDARIS. Exactly. I wish I had thought of that phrase. You hit it right on the head. That is exactly what is happening.

Mr. WYDEN. It seems to me what you have stated is that this process is clearly illegal.

Mr. HALAMANDARIS. Yes, sir.

Mr. WYDEN. Have you all challenged this in court, and if so, perhaps you can advise the committee of the results of those challenges?

Mr. HALAMANDARIS. Yes, sir. Mr. Chairman, you know that our national association regrettably after exhausting every other resource has filed suit against the Department of Health and Human Services. Those lawsuits are pending in court at the present time in an effort to restore some equity in this benefit.

I do endorse the suggestion that you made, Mr. Chairman, that there is already legislation on the books that I believe that Congressman Wyden and you have cosponsored which would remove the pernicious of the intermittent care requirement.

Again, it does not make any sense to me to deny care to somebody on the rationale that they are too sick. That is the one that ought to be removed, and you sponsored some legislation to do that.

You know, we would be very happy to follow through on you, but Congressman Wyden put it so well. It is death by a thousand cuts at the present time. Our people who are trying so hard to care for the elderly and the frail in their own homes are listening to the

Administration talk about the need to expand the scope of Medicare to provide catastrophic coverage.

At the same time they see it becoming increasingly impossible to care for the people who are now in the system. It is kind of an irony. It is something that we need to rapple with and see if we can find some solution.

Mr. WYDEN. Perhaps just one other question if I might, Mr. Chairman. All of you have been up against Government agencies and literally bounced from one program to another. What has been the attitude of the Government? Do they try to help you find other assistance, or do people just say tough luck?

Ms. KRAMER, you are shaking your head. Perhaps we will start with you, and I would be interested in each of the responses. We ought to know whether our Government tries to help citizens in need.

Ms. KRAMER. I have made several calls to Medicare, to Social Security, and as I said I have written letters to Congressmen, and nobody seems to help. I am not—at points I do get sick and I am hospitalized, but I like to go outside and I like to ride my bike.

Medicare states that I am too well because I can ride a bike, but if I do not ride my bicycle, and if I do not get treatments, I am in the hospital. My treatments are judgmental. They are survival for me.

I have breathing problems, and walking downstairs is very difficult for me at times. In the morning when I get up, I am clogged. So for me to get out of bed to go to a hospital and travel, and wait a half an hour to get my treatment is detrimental to my health because at that time I am gasping for air.

It is like a baby being born. When you slap the baby and he is able to breath, that is how I feel every morning when they hit my chest. This type of therapy is called postal drainage and percussion.

This therapy is done for an hour and on all segments of the lung. It is not just inhalation therapy which I also receive.

I have gotten no help from anybody. My insurance company dumped me. I am left with Medicare. I took a comprehensive State policy, and they say no. So what am I left to do. I am left to get sick again.

I have been traveling already for a month to the hospital, and I am finding that my condition is going downhill. Now, I am going to be hospitalized when I get back, and that hospitalization is going to last 3 weeks.

You cannot see my disability. It is in my lungs, but if you are with me 24 hours a day, you can see it.

Mr. WYDEN. You feel that you have just had your back turned on you?

Ms. KRAMER. Right, there is no help. It is like we cannot offer anything, and I do not have the income from Social Security to take care of myself. I live with my mother, and you know I help her out with her expenses. She is a secretary and she tries to help me with my treatment.

She does have arthritis. She is old. There is nothing I can do. So I am trying to survive as much as I can. I educate myself well enough to take care of my condition to see what treatments were

available and how I can go about getting certain help and nothing has come to me.

Mr. WYDEN. Would any other witness—

Mr. PEPPER. Would you yield?

Mr. WYDEN. I would be happy to yield, Mr. Chairman.

Mr. PEPPER. Ms. Kramer, you are from Miami, I notice.

Ms. KRAMER. Yes, I am.

Mr. PEPPER. I do not know whether you are from my district or not, but you are from my home area.

Ms. KRAMER. Yes.

Mr. PEPPER. And I hope you are from my district. Ms. Kathy Gardner here who is staff director of our subcommittee has taken particular note of your case. I am going to try it out administratively to see whether I can change that interpretation of your case.

Ms. KRAMER. I would appreciate that.

Mr. PEPPER. If we cannot, why we will try to include it in our efforts to amend the legislation so that people like you as well as the others will not be precluded from what you ought to be able to enjoy—home care.

Ms. KRAMER. I just had a friend of mine who had cystic fibrosis pass away, and she had written letters constantly to Congressmen. She died fighting for this.

I mean she would go to the hospital twice a day to get the treatment, and she literally could not breathe. She had intravenous at home, as you were saying IV therapy. We do get blouted with IV therapy.

It is like a cannonball hitting us each time we do get it. It was difficult, and I appreciate that I was here able to speak to you, and it is my birthday.

Mr. PEPPER. Among other things.

Ms. KRAMER. So it is like a birthday from somebody up there who gave me this present. I am very honored.

Mr. PEPPER. Does not the law require that a physician certify a patient as being eligible for home care?

Mr. HALAMANDARIS. Yes.

Mr. PEPPER. Well, it looks like that ought to have considerable weight.

Ms. KRAMER. But there is a clause in the Medicare.

Mr. PEPPER. When a physician qualifies an individual for home care, that ought to have a lot of weight it would seem to me.

Mr. HALAMANDARIS. Well, Mr. Chairman, if I might, they overruled the judgment of the physician. In every one of these cases where I have given you the box to show you that care has been denied for some reason, they overruled the judgment of the physician.

Mr. WYDEN. I think two of our other witnesses want to comment on it. The only point I would say, Ms. Kramer, you are very fortunate to have the premiere advocate for senior citizens as your congressman.

There is not any question that you are going to get help, but the tragedy is, and the reason I have asked this of all our witnesses is that we cannot really put Senator Pepper in the xerox machine and make thousands of copies of him.

The Government has got to step in and help. I would like to hear from several of our other witnesses about their experience with the Government so we could see what it takes to get Government to come to your assistance.

Mrs. OPPER. Well, as I said my husband is retired from the House staff as a matter of fact on a U.S. Civil Service disability pension. At the time he retired he had 4 years and about a half of Social Security covered employment as well.

So we were not eligible. He was not eligible for Medicare period. So everything we did was more or less through the private sector.

I would like to also mention that taking care of a patient at home, I mean you are getting a little thread of this in what people are saying requires an enormous amount of support. It is not a simple thing.

It takes a huge amount of help and support. You need to know where the nurses are not only to find out how to pay for them, but to get the qualified nurses and make sure they come when they suppose to come. It is not a simple thing.

Mr. WYDEN., Mr. Fiterman?

Mr. FITERMAN. Well, I hope you know we need your help.

Mr. WYDEN. Well said. Well said. Mr. Halamandaris?

Mr. HALAMANDARIS. I believe, Mr. Chairman, I have said my piece. I do not think I need to add anything more.

Mr. WYDEN. Thank you very much, Mr. Chairman.

Mr. PEPPER. Thank you Mr. Regula?

Mr. REGULA. Thank you, Mr. Chairman. I have a number of questions that I will waive because I know we have the other panel here. Just one quickly, Mrs. Fischer. In retrospect to your knowledge had you known this challenge would confront you, would you in fact have been able to buy any kind of insurance coverage that would have met the needs in your situation even had you known?

Ms. FISCHER. No. When we purchased this particular policy in 1976, it was very definitely the most comprehensive policy available to us at that time and really still is, but that \$10,000 cap is an absolutely devastating situation.

We first started with this in 1984, and we absolutely exhausted every public official, every office, every advocate, every agency, every intermediary who tried to help us to do what could be done to waive the \$10,000 cap which they would not do.

Because we have such wonderful comprehensive insurance, we were denied the waiver in Michigan based on the fact that we have excellent insurance. It was a ludicrous situation in that we were being penalized for being middle class people who paid for our own insurance and were not eligible for aid of any kind.

This new mental health waiver which we applied for for the first time in 1985 because they had the cap again last year, because I am a RN they allowed me to administrate the \$10,000 which saved part of the cost in the \$10,000, has a cap on it of just a little over \$19,000.

So when you put \$19,000 and \$10,000 together, you are coming up with \$29,000 in an annual period which she requires so much more care than what that brings to us.

Now, we are in our \$10,000 right this minute for 1986, and we absolutely have nowhere to turn. This is our third year at repeating this ludicrous situation with our insurance.

Now, we continue to pay our premiums and receive no benefits. We were denied services by our vendor based on lack of reimbursement. As Katherine continues to survive because she is more debilitated, her care becomes more complex than ever.

Mr. PEPPER. Well, thank you. You have all been a wonderful panel. We are very grateful to you. Thank you very, very much.

Now, we have another very distinguished panel. I will ask them to come to the table if they will. The Honorable Joseph A. Califano, Jr., former Secretary of Health, Education and Welfare, eminent attorney and great American who has been one of the leaders in trying to provide better medical care for the people of this country.

Next is Mr. Marvin Cetron, Forecasting International, Limited, Arlington, VA. The next is Dr. David Blumenthal, JFK School of Government at Harvard University, Cambridge, MA. It is a pleasure and an honor to have all of you here.

Mr. Califano, again, we are grateful to you for being with us, and we welcome your statement.

PANEL TWO—THE NATIONAL PERSPECTIVE: CONSISTING OF HON. JOSEPH A. CALIFANO, FORMER SECRETARY OF HEALTH, EDUCATION AND WELFARE, WASHINGTON, DC; MARVIN CETRON, FORECASTING INTERNATIONAL, LTD., ARLINGTON, VA; AND DAVID BLUMENTHAL, M.D., EXECUTIVE DIRECTOR, CENTER FOR HEALTH POLICY AND MANAGEMENT, JOHN F. KENNEDY SCHOOL OF GOVERNMENT, HARVARD UNIVERSITY

STATEMENT OF HON. JOSEPH A. CALIFANO

Mr. CALIFANO. Thank you, Mr. Chairman. Mr. Chairman, it is a pleasure to be with you today to discuss the Medicare and Medicaid Programs as special counsel to the National Association for Home Care.

I was fortunate enough, Mr. Chairman, to participate with you and many others in the creation of Medicare, Medicaid and a host of other programs. Together we changed the course of health care in the United States.

We provided health care for the old and the poor, established clinics, provided funds to train doctors and nurses and enlarged the National Institutes of Health.

We felt it was the responsibility of those who have to provide health care, those who have to provide health care for those who have not, the vulnerable of our society, the poor, the elderly, and the sick.

Our focus was on hospital care for the elderly and the poor. It was a job well worth doing. I am proud of what we accomplished as I know you are.

As a result, access to hospital care is no longer a problem. Life expectancy has increased dramatically and infant mortality has dropped. Federally funded research has produced medical miracles.

Now, Mr. Chairman, 20 years later several of these programs are under attack. Medicare, Medicaid, and other other health programs have been subjected to a series of cuts.

Some programs have been eliminated and Government has shucked much of its responsibility to provide care for the poor and the elderly. Instead of tackling the tough job of restructuring the health system, by and large, the Feds have simply shifted costs like peas in a shell game to business, unions, States, cities, and individuals.

What concerns us most about current trends and policies is the indiscriminate nature of the cuts and the lack of foresight in their implementation. As Secretary of Health, Education, and Welfare, in the late seventies much of our focus was on controlling costs, but we constrained our efforts by the overall objective to establish quality health care as a basic right in this Nation.

Today's indiscriminate cost cutting ignores the health needs of our people and efficiency in the delivery of health care. The 1-percent solution of Gramm-Rudman is at best an act of political cowardice, at worse a savage blow against the most vulnerable in our society.

Hospitalization, institutional care, and alternatives like home health care are equally attacked. Rather than attempting to eliminate the tremendous waste in the system, costs are shifted like peas in the great health care cost shell game.

Nothing is achieved. The system is no more efficient. As a Congress, as a government, and as a people, we must muster the courage to eliminate waste and inefficiency in our health care system which I am convinced runs at a stunning \$100 billion a year, about 25 percent of the nation's health care bill, largely because of unnecessary surgery and hospitalization. I might note that this morning's edition of USA Today also indicates that this is the amount of waste in our system.

The key of such a strategy is to encourage the use of less expensive procedures like home health care by reimbursing for such care even more fully than we presently reimburse for expensive hospital and nursing home care.

It is now possible to do just about anything at home that is done in a hospital. That was not the case 20 years ago when we developed Medicare. We ought to modify our policies to reflect current medical realities.

The simple fact is that while we have generously reimbursed and recognized the development of technology in the institutional setting, all too often we have not recognized the benefit of increased efficiency of the same technology in the home.

We have the resources to provide all the health services our citizens need if we eliminate waste, and inefficiency, and nourish cost effective service delivery systems like home care.

Much of that effort I am convinced requires a new focus. We have to persuade Government and private insurers to begin to provide assistance for people who have chronic conditions, people who need long-term care in their homes, the terminally ill who deserve the dignity of ending their days in the hands and arms of their loved ones rather than in the grip of plastic and steel tubes and needles.

Instead of manipulating the regulations to restrict home care, we ought to be expanding these services. Cutting reimbursement for

home care is not just cutting off our nose to spite our face. It is more like beheading ourselves to shave our whiskers.

If you will forgive a personal reference, Mr. Chairman, my mother is over 90 years old. She is bedridden as you know. You know my parents well, Mr. Chairman. At one point her doctor wanted to put her in the hospital.

His chief argument for doing that was that none of the services she needed could be covered by insurance or Medicare if she stayed home, but if she were placed in an intensive care unit of a hospital at a cost of over \$600 a day, Medicare and insurance would have paid the whole bill.

My father and I decided she would prefer to be in her own room in her own house. Fortunately, we were able to give her that choice, but most people are not that fortunate, Mr. Chairman.

We have got to rethink the nonsensical policies that create such distortions. We must—

Mr. PEPPER. Wait just a minute. You bring back reverberation of what my dear mother used to say to me. "Son, do not ever let them put me in one of those nursing homes."

She did not mean to disparage nursing homes. She did not really know anything about it, but she did know her home. Fortunately, just as your mother is able to do, my mother was able to stay in her home until the end. I know what it meant to her. Excuse me.

Mr. CALIFANO. That is exactly, Mr. Chairman, what my mother said to me many, many times and to my father. "Let me stay in the home."

We must put far more resources into home care. In the long run that investment will earn us enormous dividends in humanity and self-respect. It will also save us a lot of money, and it will allow us, Mr. Chairman, to move ahead on the job we started 20 years ago. Thank you.

Mr. PEPPER. Thank you very much.

Mr. CALIFANO. Mr. Chairman, I would also like to give you something if I may. This is my book, Mr. Chairman, dedicated with an inscription to you. It makes the case for so much that you have fought for.

Mr. PEPPER. Very good. Well, I am delighted to have this. One of the greatest of my prayers is that the Lord will let me live long enough to see what Mr. Califano is talking about here comes true. You are helping to do it. Thank you very much.

Our next witness is Mr. Marvin Cetron, Forecasting International, Ltd., of Arlington, VA. Mr. Cetron, we are glad to have you.

STATEMENT OF MARVIN CETRON

Mr. CETRON. Thank you. Thank you, gentlemen. I would like to cover a lot of different areas very quickly, and I have got some highlights. Then I have a statement which I would like to put in for you.

Let me start by saying with the DRG's we have people leaving hospitals quicker and sicker. They are getting back home. They are using health care by using ambulatory care centers; or "Doc in a Boxes," or 7-11 medicine; 80 percent of our people are not using the emergency rooms any more because of these ambulatory care

centers. The truth is the rates are not being set by doctors. The treatment is not being set by patients.

It is being set by third party payers and insurance companies. In reality, if we take a look at what is going on, doctors have not had a pay increase since 1983. They are paying 8.9 percent of the money they paid today in insurance fees, and in addition it goes to 15.1 percent in terms of insurance fees.

So we are finding a major change taking place. Third-party payers are controlling what goes on at the present time. We are finding DRG's may be saving money, but they are leaving home quicker.

Therefore, we are getting back into something which is entirely different. The third largest industry today, the third largest today is the health care, home care, and medical business.

It will be the largest in the 1990's. We are now spending \$440 billion per year on health care, home care, medical insurance, genetic engineering, and enzyme research. As Mr. Califano brought out earlier, one of our major problems is the technology is here today. They handle it differently, and it is not being done.

By 1987, that is next year, 50 percent of our homes will have interactive cable in them. By 1991, 92 percent will have interactive cable. We can have medical diagnostics at home.

These can be taken care of at home, and the costs are usually, your savings is 60 percent. We are paying 40 percent for the care of people at home as opposed to staying in the hospital itself.

So the costs are tremendously large, and it is a place to have your savings. I think we have got to get down to realize that at the present time—I am sure most people understand—we have 15,000 people today over 100 years old. That is today.

By the end of the year 2000, we will have 100,000 people over 100 years old. That is our major problem.

Willard Scott will not be able to put their names in the "Today Show" any more.

Mr. PEPPER. I guess it is no secret that I am hoping to be among that group.

Mr. CETRON. We are hoping that too. So we are saying that those are the things as part of this study and with all due respect our book from McGraw-Hill on "Health Care and Home Care Into the Twenty-First Century" will be out in about 5 months. We will have it join yours.

We made a study for the National Association for Home Care, physician assistants, and the American Pharmaceutical Association, and we had help from the American Academy of Physicians, and from the third-party payers, and nursing associations, et cetera, we collected data on this study for home care in the future.

The objective was really to explore the future of home care industry with the primary focus on home care itself, and what was happening to health care. We contacted 1,200 people in the 48 contiguous States by telephone, spent roughly 9 to 10 minutes with each individual finding out what they felt was important.

What they thought was not important. What was their experiences in this and especially in home care through utilization of nursing assistance and geriatric social workers, et cetera.

The results I think I would like to give very quickly and have the paper brought in for its own information and for your information for analysis later. The studies showed these final facts.

One, 73 percent of the public and the Government said the Government and private insurers should provide catastrophic insurance. That is 73 percent. This came from all the States as I mentioned earlier; 65 percent of the public said that Government and private insurers should provide long-term care coverage based on home care; 72 percent of the American public preferred home care over nursing home care for persons who need frequent medical and housekeeping assistance; 85 percent of the public favored insurance plans and encouraged the treatment of chronically ill people at home instead of in the nursing home itself; 77 percent of the public favored medical IRA's which encourage individuals to save money now for use for medical expenses after their retirement; 47 percent, they felt very favorably about the idea itself, putting money away now for later on. In fact, I know that yourself, Congressman Pepper, has introduced a bill to allow this practice encouraging the credits. I know that Mr. Regula has also, and I think that that is well overdue.

Prepaid health plans already have 17 million members, and it will grow in the next decade itself, as I am sure that you are well aware. The computer-assisted diagnostic information is changing the technical capabilities of health care professionals in three ways. One, the ability to diagnose patients at home via the telephone and computer, an interactive cable. And as you know, every cable put in since 1973 is two cables, one going in and one going out.

And then you can take care of things such as monitoring the patients at home, test kits at home, and diagnosis at home as well as medication at home. One of the problems that you have with the aging is there are three major problems, one of which is they have a choice between food, heat, and medication. In most cases, the poor do without the medication. This is one way to make sure that they can get their medication.

The middle class, they tend to forget sometimes to take their medication as they get older. And the wealthy say I have got to take 4 pills for 10 days, and I am well off enough that I can take 8 and I can take it for 5 days, and they end up in the hospital also. So you have got different kinds of problems involved as we get older.

The new techniques that we have now for putting Band-Aids behind the ears and getting medication going in over a 5- to 6-year period. By putting pumps inside to take care of insulin for diabetics that can be taken care of at home. By having new types of IV's that can be used at home, they can have the medication when they need it and in the dose that they need it at the proper time. So these things make it more possible there.

The second thing is the ability to input patient information, and have the computer provide a logical diagnosis. They can pump in what the data is, they get back a reading, and they can see what ought to be taken care of including calling a doctor or geriatric health.

The ability to recreate the insides of the body in multidimensions with computer-assisted x rays, sonograms, and radiation scanners with the CAT scans, PET scans, and MR's. They are crucial, and the problem is again it is home care.

The average CAT scan, PET scan, and MR's are used less than 2 hours a day 5 days a week. They can be put on trailers, moved around. And they can be available for community-based health care. Everybody can use them. You need not have a doctor's degree or be a MD to do the CAT scan reading, PET scan reading, or MR's. They can be available, and the doctor can look at them the next day. But these things can be moved and they can be utilized. We are not using them effectively, and this can be used in community-based health care again.

I think that what I am saying in essence is that we have now artificial hearts, we have artificial arms, we have artificial legs. My son is getting his degree in 2 months from the University of Utah using biofeedback and a microchip to move the Utah arm. He has it connected with a Stanford hand, and the MIT fingers. He can take a roll of quarters and turn one quarter over at a time. He can flip a quarter up in the air and catch it.

These are the things that are going on today in prothesis. I told him, I said: "Hey, I can do that too." He says: "Yes, but can you do this?" And he cracked an egg, threw the shell away, took an egg, and while it was cooking, he stirred the egg up.

So there are things that can be done. But the point that I am trying to bring out is that we have these things available. We have vasopressin, new nasal drugs to bring back memory for older people. We have artificial blood, we have artificial skin. Things are happening now in the medical area so quickly that we cannot keep up with them philosophically, and we sure are not keeping up with them as far as the Congress goes.

You know, here we are preaching to the choir. This is not doing any good at all. We have got to get out to the public itself, and it is not getting out to the public. I think that Gramm-Rudman is not going to help this situation. In fact, if you want the truth, Gramm-Rudman is a bad idea whose time has come.

It is about time that we realized that we can keep the cuts that we have to take from other places and put them into things such as home care, medical care, and especially hospice care, and critical insurance. Thank you very much.

[The prepared statement of Mr. Cetron follows:]

PREPARED STATEMENT OF DR. MARVIN CETRON, FORECASTING
INTERNATIONAL, LTD., ARLINGTON, VA.

Mr. Chairman:

The changing face of health care in the United States can be measured in terms as small as breakfast and as big as national defense policy. Technology has produced thermometers that can be worn like wristwatches and implants that take the place of vital organs. Hospitals save lives today that were lost 25 years ago in their own emergency rooms. Run down a list of diseases cured in the last 50 years and you have an index to illnesses that routinely devastated the human race, diseases that killed millions of our ancestors before they ever reached old age. Yellow fever, scurvy, cholera, smallpox, diphtheria, polio, meningitis, tuberculosis and malaria, to name a few. If there is one meaningful statistic about where 20th century medicine has taken us, it's the one triggered by penicillin. In 1940, infection caused 25 percent of all deaths. Today, it's less than three percent. There's another statistic that makes the same point. Man's life span at the start of the 20th Century was 45 years. Today, it's 74 years. Time was when a person who lived to be 100 made news. No longer. Today, there are 15,000 Americans over 100 years old. When the century turns again, the number of 100-year-old Americans is expected to be 100,000.

We've paid a high price to get where we are today. Americans spend almost \$1 billion a day taking care of themselves. The business of health care is Big Business, ranking as the nation's third largest industry, spending \$300 billion a year, growing at a rate of 11 percent a year and accounting for 11 percent of the country's GNP. The federal government alone pays out more than \$90 billion a year to defray the cost of health care in the United States. The most important new health care development is the Medical-Industrial Complex, the \$60 billion-a-year industry that involves hospitals and nursing homes, diagnostic laboratories and emergency room services, all of it for profit. Get this. Private industry now spends almost \$90 billion a year on health insurance, almost double what it paid out in 1980. What this has done is thrust corporate America into a new role as health care policymaker, a role that private industry does not relish. "Corporations are now being asked to play God with

their money," says one official of a Fortune 500 company. "It's a brutal issue, the most sensitive thing companies have had to deal with in employee relations. Our employee benefits man walks around here with bags under his eyes."

Despite the help they now get from their employers, the average American can no longer afford to get sick or injured on the job. Hospital room rates have doubled in the last 10 years. Per-capita health spending has risen from \$221 in 1965, the last pre-Medicare, pre-Medicaid year, to \$1,365. Post Medicare? Hospitalization costs for Medicare that used to run \$3 billion a year now run \$3 billion a month. The cost of Medicare is now growing twice as fast as the payroll tax that finances it.

Enough. There are answers to all this and they don't involve draconian measures like socialized medicine or freezing the fees that doctors and hospitals can charge. Let's face facts. We need a different approach and only one makes sense. Let's move the nation's patients out of our hospitals and out of their doctors' offices to where they won't go broke paying to get well again. We're talking about the home, the hospice, the walk-in neighborhood clinic, the health maintenance organization and the freestanding outpatient surgery center. What some people call "Doc-in-the-Box," "McDoc" or Seven-Eleven Medicine. Convenience health care. Critics say all they do is offer quick cures for small ills like broken bones but critics don't have to pay the \$10,000 the upscale orthopedist and his university hospital collect for a badly broken ankle. One statistic is enough to make the point. Blue Cross says the average hospital emergency room visit is now \$165. The Walk-In Medical Clinic of Benning Road in Northwest Washington says its average charge for a visit is \$45. The AmericARE 1 in La Habra, California says its average charge is \$40.

Seven-Eleven medicine is an idea whose time has come. In fact, the trend is already up and running. In 1978, there were 482 agencies backed by accredited hospitals sending nurses and paramedics into homes throughout the United States. By 1982, there were 784. Today, it's more than 1,000. In the same eight years, home care agencies without hospital ties grew by 64 percent.

Do people want to be treated at home? Do they prefer the neighborhood clinic to the community hospital? The answer overwhelmingly is "YES". A nationwide sample of the American

Association of Retired Persons showed that 80 percent of its members chose home health care over nursing homes. Every Harris and Gallup poll has backed home health care. The Surgeon General of the United States because he believes its time has come. The Comptroller General because it's less expensive than hospitalization. A majority of the nation's medical schools. The American Nursing Association. President Reagan. Let the venerable chairman of the House Subcommittee on Health have the last word. "I can remember my mother telling me, 'Son, never let them put me in a nursing home'," Rep. Claude Pepper (D., Fla.) said. "She didn't mean to disparage nursing homes. What she meant was that she wanted to stay in her own home among her own possessions and family surroundings."

Fueling these trends toward home health care are the nation's two largest population groups. One is America's elderly, the other is America's young. Look at the facts. Senior citizens make up the fastest-growing group in the United States, now comprising almost 12 percent of the nation's people. From fewer than 21 million in 1972, the ranks of Americans over 65 grew to 23 million in 1978 and more than 25 million by 1983. In the next 10 years, the country's seniors will grow to almost 30 million and by the year 2000 reach close to 33 million. That's a lot of people, who more than ever, want a break out of life in their waning years. "There are few issues of greater importance to the nation's elderly than home health care," says Florida's Rep. Pepper, one of the most powerful committee chairmen on Capitol Hill. "Old age brings with it a decrease in mobility and an increase in disability. Which robs seniors of their independence and limits them in what they can do for themselves."

America's children make up an even stronger driving force for home health care. There are 75 million children in the United States. Most people don't know that 10 million of those children are chronically ill. One to two million of those 10 million are "severely impaired," meaning they have leukemia, cystic fibrosis, diabetes, muscular dystrophy, kidney disease or hemophilia. Almost without notice over the last 25 years, the number of kids with these disabling diseases has doubled, doubling the number of chronically ill children to four percent of our children's population. Why? Infants who never lived now survive the trauma of premature birth but they survive with the chronic illnesses that often beset premature children. Digestive difficulties. Poorly built lungs. Deafness.

Blindness. Nervous disorders. The list is endless but it's putting more and more of America's children into hospitals their families can't afford.

The children can't afford it either. Listen to a hearing held in June, 1985 by Sen. Orrin Hatch (R., Utah), chairman of the Senate Committee on Labor and Human Resources. Hatch starts the hearing with an anecdote based on fact. "Imagine a little girl born prematurely, weighing only two pounds, three ounces. She is allowed to leave the hospital after two months but is readmitted with viral encephalitis four months later. During the next three years she fights the devastating after-effects of this debilitating respiratory disease. Unfortunately, when her doctors prepare to release her from the hospital, her family discovers that Medicaid will not cover the cost of her care at home. Would this child be better off at home with the same quality care provided by the family she loves at a savings of \$30,000 a year? I think the answer is obvious."

The solution is obvious but there are roadblocks to the solution. Like state laws that prohibit any kind of reimbursement to people paying for Seven-Eleven Medicine. Washington's Childrens' Hospital serves Maryland and Virginia along with the District of Columbia. In June of 1985, there were two children at the hospital that were ready to be sent home. One was a boy with a rare muscle disease, the other a girl born prematurely. Yet, the children remained in the hospital because they both live in Maryland, which will not pay for the care they need at home. These children are not alone and Maryland isn't alone. More than half the states have the same law on their books.

Medicare is burdened with similar laws. Only "intermittent" skilled nursing or "intermittent" home health aide care is covered under Medicare. Physical, speech, and occupational therapy is also limited. To receive home care coverage, patients must be "homebound" -- patients are often deemed ineligible because they have acquired too much mobility or because their out-patient chemotherapy or hemodialysis treatments cause them to leave home too frequently. Varying and inconsistent interpretations by fiscal intermediaries mean the number of visits per day, number of days per week, and number of weeks total a patient may receive reimbursement is restricted. The "skilled nursing care" restriction can deny reimbursement because specific care was not "skilled" and should have been completed by an aide or family member.

Progress has been made to remedy these inconsistencies but we've got a long way to go. Powerful forces are at work driving the nation toward home health care. Techniques that allow people to monitor, test, diagnose, and medicate themselves have put them more in charge of their health. The fitness craze has also contributed this feeling that we are each responsible for our own wellness and have options when it comes to sickness. New drug and medical technologies will help make the chronically ill less tethered to their illnesses. Like "wrist-paks" to monitor body functions and dispense the correct drug dosages to keep the afflicted in control. Tiny sensors attached to a patient's skin will soon allow doctors to perform instant diagnosis of a patient on the move. The result? Less need to visit a doctor or check into a hospital.

Another powerful force afoot driving the country in new health care directions is a growing surplus of doctors. This surplus, especially of heavily indebted new doctors just emerging from medical schools, will serve to keep salaries and fees down at walk-in clinics, HMOs, emergicenters, surgicenters and for-profit hospitals that tend to view doctors as employees and nothing more. This trend is sure to grow as the doctor glut grows. How much will it grow? By 1990, there will be 245 doctors for every 100,000 Americans. That may not sound like much but it's almost double the number we had in 1950.

The future of health care will gradually shift to home care and community-based services; primary health providers, especially doctors, will follow consumers. This is not to say that other health care options will not continue to develop, but they will have a community base. Doctors, nurses, pharmacists, physician assistants -- and health plans such as HMOs, PPOs, and IPAs -- will integrate their services into the home care context. In lieu of this, FI recommends a policy whereby home care is tax-deductible and reimbursed from the public and private sector when used as an alternative to prolonged hospitalization or permanent nursing homes.

In fully integrating their services into the community, hospitals should make available their diagnostic equipment for regular checkups. Mobile diagnostic/treatment units with paramedic personnel can bring the health provider to the consumer. This is particularly useful in minority areas and among the elderly -- two groups which may encounter difficulties when trying to get to a

health facility. These mobile units could provide gynecological exams and counseling, blood pressure checks, colorectal cancer tests, urinalyses, inoculations, and other routine tests. More sophisticated tests could also be performed such as CAT scans, PET scans, and evaluations with MRIs. Since the equipment needed for such technologically advanced tests is so very expensive, tests should be performed around the clock, during times convenient for consumers. Mobile units allow health care reach beyond existing facilities into communities where a tremendous need exists.

Our country needs a catastrophic medical insurance program to cover hospital care, home care, and nursing home care. Present health care systems leave little choice between independent living and living in a nursing home, completely dependent upon others. Such an abrupt change can be a tremendous shock to older Americans stricken by a stroke or other illness. Many seniors have lived at the same address for most of their adult lives. Institutionalization may cause listlessness and boredom lacking a daily routine of tending to their own shopping, cooking, cleaning, laundry, home maintenance, etc. Their physical condition often deteriorates. While not all nursing home residents fall the category discussed above, an intermediate care system is needed to bridge this gap.

Nursing home costs hit all residents equally hard. With annual costs of up to \$25,000, the present institutionally-based health care system encourages the "spending-down" of resources. Homes, cars, furniture, stocks, bonds, and savings are needed to pay the exorbitant costs of institutionalized care. The nursing home resident often "goes on" Medicaid to pay for their care. This promotes a further loss of self-esteem and self-respect. Long-term and catastrophic health insurance are sorely needed.

In one proposed catastrophic insurance plan, once a health care consumer reached his annual income level, 45% of costs would be paid by the employer or policy-holding insurance company, 45% would be paid by the federal government, and roughly ten percent would be paid by the individual or his family. This would make adequate medical care financially acceptable -- a crucial issue for the elderly.

Our 20th century cost-containment efforts will pay off when we channel those monies back into the home care programs which provide a much preferred alternative to institutionalization, and into long-term and catastrophic health care insurance which gives our present and future generations of seniors peace of mind in their "golden years".

Mr. PEPPER. Thank you. Mr. Cetron, your presentation is excellent.

Mr. CETRON. Thank you very much.

Mr. PEPPER. Mr. Cetron, we are working very diligently, as you know. We have introduced some legislation, and we would like the privilege of conferring with Mr. Califano and Dr. Blumenthal in an effort to help us try to move forward toward some sort of insurance program that will have the objective, and we hope that we will gradually realize it, of providing needed medical care to all of the people of this country following the excellent statement made in Mr. Califano's book.

And by the way, I think that the people here today would like to know that this is on the front cover of Mr. Califano's book: "There are no more excuses for hand wiggling and finger pointing about our health care crisis. Joe Califano's tough-minded common sense may offend some people and certain others, but his ideas will also give us a health care system that costs less and is more rational, productive, and humane. Lee A. Iacocca," another great American. And Mr. Califano was on The "Today show" this morning, but he released his book. And I shall write him thanks for the generous inscription that he has on the flyleaf of his book for me.

Now Dr. Blumenthal, we will be pleased to hear from you.

STATEMENT OF DAVID BLUMENTHAL

Dr. BLUMENTHAL. Thank you, Mr. Chairman. It is a pleasure to be here today to discuss with you issues that are related to catastrophic illness and long-term care protection. My name is David Blumenthal, and I am the executive director of the Center for Health Policy and Management at the John F. Kennedy School of Government at Harvard.

I do not have a book that I have recently published, but we do have a report, Mr. Chairman. I do not have it with me because—

Mr. PEPPER. We are very grateful for your report.

Dr. BLUMENTHAL. I would be glad to provide it to you. We have just completed a 2-year study of the Medicare Program, and a summary of that study appeared in the New England Journal of Medicine last week. I would be glad to submit that for the record, if you so desire as well.

Mr. PEPPER. We would be delighted to have it.

[The report, entitled "Medicare: Coming of Age—A Proposal for Reform," dated March 1986, has been retained in subcommittee files. Copies may be obtained from: Center for Health Policy and Management, John F. Kennedy School of Government, Harvard University, Cambridge, MA 02138.]

Dr. BLUMENTHAL. Thank you.

Mr. PEPPER. Thank you.

Dr. BLUMENTHAL. We have made in that report more than forty specific recommendations on how the Medicare program might be revised to improve its functioning for the Nation's elderly, and most of our recommendations did address the problems of the elderly.

As you have seen from your panel earlier today, those problems, of course, often affect the nonelderly as well, those who are eligi-

ble for Medicare and those that are not. But most of my discussion today will concern our report, and it will focus on the problems of the elderly.

Before doing so, let me say that I know that academic reports are often rather dry and difficult for people to understand. I would like to say just for the record that I do have some personal experience with problems related to long-term care, and the home health care, and catastrophic illness as well.

As an internist and a physician on the staff of a tertiary care facility, I have a large proportion in my personal practice of elderly patients, particularly the very old, elderly patient, those over 85, those that are subject to a very high probability of catastrophic illness and of the need for home care.

Just last week, the day that our New England Journal article appeared, I have two personal experiences that made it very real to me the problems that we were trying to deal with in this area.

First of all, an 88-year-old patient of mine who has been healthy for his age until very recently, but recently had a heart attack and developed diabetes, and was discharged from the hospital with diabetic leg ulcers had his home health services discontinued because, and I do not know exactly why, but because he obviously violated some of the sides of the box that you have heard about. I do not know exactly which one he violated, but I do know that the availability of that care kept him from having to visit me as frequently, and was probably resulting in cost savings to the system.

That very same day, the daughter-in-law of a 92-year-old patient of mine, who recently quite miraculously survived an attack of acute colon cystitis, called me and asked if I would forgive her physician's bills, because the family no longer had the resources to pay for her care. I did so, but I realized that I had no idea how much those people were paying out of pocket. I did not know their personal situation.

But I would just like to point out that as we strive for an efficient health care system, and strive to make physicians more productive, it is going to be harder and harder for physicians to take the time to find out what the personal financial circumstances are of the patients that they treat. Therefore, the amount of free care that they give may decline as a result. That is an aside.

Let me just go on to some of the key findings of our report, Mr. Chairman. First on the question of catastrophic illness, there are a few statistics that you all may be familiar with. We estimate that every year that 2.5 million elderly Americans spend more than \$1,000 a year on their health care services.

We also know that there is a popular misconception that the elderly that incur such catastrophic illnesses are within a year or—

Mr. PEPPER. Excuse me, Doctor. We also have a figure that some 4 million elderly become impoverished every year because of the medical costs that they have to bear.

Dr. BLUMENTHAL. That seems quite consistent with our information, Mr. Chairman. There is a popular misconception that the elderly victims of catastrophic illness generally incur their expenses at or near the time of their death, within the last year of their life. But the Health Care Finance Administration has statistics avail-

able that show that two-thirds of those on whom Medicare spends more than \$20,000 a year will survive the year in which that illness occurred, and will live to have to handle the cost burdens, the out of pocket payments, that are associated with those catastrophic illnesses.

There is also a misconception that catastrophic illness expenditures for the elderly result importantly from long extended stays in the hospital, those over 60 days that exhaust the period of free care, the forgiveness of the coinsurance provision. But it does not take a genius in mathematics to understand that with the current deductible provisions of Medicare approaching \$500 for each hospitalization, that three hospitalizations in a given year can run up a bill not including any other coinsurance requirements, or any physician deductibles, or physician expenditures of \$1,500, which is a substantial part of the income of many elderly Americans.

Because of these findings and the concomitant finding that co-payments for Medicare beneficiaries are increasing at twice the rate of their income at the current time, we recommend that the Medicare program cover the costs of catastrophic illness among elderly Americans.

In particular, we recommended that no elderly individual eligible for Medicare be required to pay more than \$1000 annually in the form of out of pocket payments for Medicare services that are currently covered by that program.

We further recommended that that coverage be part of the general beneficiary benefit package of Medicare, that it not be treated as a separate voluntary program. We feel that this is the most practical, and equitable, and efficient way to provide it, and I would be glad to elaborate on why that is the case later on.

The plight of elders with chronic illnesses is also well-known to you, Mr. Chairman, and to the committee, and is well-illustrated by the testimony that you heard previously here today. We closely examined the issue of long-term care needs for the elderly population. Like many others, we have concluded that the current situation with respect to long-term care and home health-care services is untenable, that it robs the elderly of their dignity at a very vulnerable time in their lives, and often is terribly destructive to family situations, as you and Mr. Califano know from personal experience.

The requirement that people be hospitalized or put into an institution often is harder to bear than the expenditures themselves. But the fact remains that expenditures for long-term care are the single largest out of pocket health care expenditures currently for the elderly.

At the average annual rate of \$20,000 a year now for nursing home care, the typical elderly individual in this country will be bankrupt within 13 weeks of entering a nursing home.

Alternatives to nursing home care for chronically ill elders, especially those living alone, are inadequate as the testimony here has very clearly documented this morning.

Once again, we have concluded that Medicare, and again addressing the Medicare Program specifically in this report, that Medicare cover the extended nursing home and home health care costs of elderly Americans. We think that the inclusion of the

home health care benefit is essential if only to reduce unneeded nursing home costs.

As you may know, 10 to 30 percent of those currently institutionalized in nursing homes, it is estimated, could be kept at home and treated in a much less costly fashion if adequate home health care services were available.

It has been proposed that private insurance companies may be able to provide for the needs of the chronically ill through the provision of home health care services and other long-term care services. While we recognize what the private health care industry has done for this country in so many other ways, we do not think that that is a practical suggestion for a number of reasons that I would be glad to discuss with you.

We have a number of specific suggestions for controlling unnecessary utilization under home health care or nursing home care benefits, and we again would be glad to discuss those, as well as our provisions for financing which will be in any case provided to you in our report and the New England Journal article for the record. That concludes my remarks, Mr. Chairman.

[The prepared statement of Dr. Blumenthal follows:]

PREPARED STATEMENT OF DAVID BLUMENTHAL, M.D., EXECUTIVE
DIRECTOR, CENTER FOR HEALTH POLICY AND MANAGEMENT, JOHN
F. KENNEDY SCHOOL OF GOVERNMENT, HARVARD UNIVERSITY

At age twenty, the Medicare program has done much to promote the health and well-being of America's growing elderly population. Nevertheless, the program has serious deficiencies that, if uncorrected, will leave more and more aged Americans unprotected against the cost of illness and unable to gain access to needed health care services.

What are these deficiencies?

First, the Medicare program is needlessly complex. It consists of not one program but two, one covering hospital services, the other predominantly physician care. Each program has its own set of intricate regulations governing coinsurance and deductible provisions, methods of paying providers, exclusions from coverage, and eligibility requirements. As a result, too many elderly Americans do not understand what Medicare covers and what it doesn't, how to plan for their health care expenses, or where to go to find out.

Second, the Medicare program fails to protect elderly Americans adequately against the costs of covered services. As a proportion of beneficiaries' income, coinsurance and deductibles have almost tripled since the program began, and are predicted to grow twice as fast as elders' income in the next decade. We estimate that each year 2.5 million elderly incur over \$1000 in copayment expenses. In the past year, the Medicare hospital deductible alone increased by 23 percent, from \$400 to \$492. Elderly Americans now pay 15 percent of their income annually for health care: exactly the same proportion as before the Medicare program was enacted.

Third, the Medicare program is unfair to low-income elderly, who pay one quarter of their income annually for health care, compared to less than 3 percent for high income elders.

Fourth, Medicare fails to cover essential services. It does not pay for any chronic home health or nursing home care. It provides only the most minimal mental health care coverage (\$250 annually: the elderly have twice the rate of untreated mental illness as any other age group). Medicare fails to cover essential primary care and preventive services.

Fifth, for services Medicare does cover, it often pays providers too much, or pays them in arbitrary and capricious ways. From 1980 to 1984, the costs of physician services under Medicare increased at an average annual rate of 18.5 percent. Specialists are paid 20 to 50 percent more for a routine office visit than are primary care physicians.

Because of these and other deficiencies, the Medicare program is more complicated, less equitable, and more costly than it should be. After two years of study, the Harvard Medicare Project has concluded that Medicare's problems cannot be fully remedied through piecemeal reforms. We are suggesting comprehensive changes designed to provide elderly Americans reasonable protection against illness and its costs at a price the nation can afford.

First, we propose several reforms designed to make the program simpler and more understandable for elderly beneficiaries. The elderly should continue to pay their fair share of program costs, roughly 25 percent, as they do now. But they should pay more of these expenses through premiums -- regular, predictable, yearly payments -- and less through coinsurance and deductibles. Coinsurance and deductibles create confusion over which services are covered, and to what extent. They result in numerous, unpredictable payments that fall more heavily on the sick, since they are incurred at the time services are used. The group also feels that the two major parts of the Medicare program should be merged into a single program with one set of regulations governing eligibility and coverage.

Second, to limit the health care expenses the elderly incur, Medicare should cover the costs of catastrophic illness. No elderly American should have to pay more than \$1000 yearly in coinsurance and deductibles. The cost of providing this protection, roughly \$1.5 billion (assuming that proposed changes in other copayments have been adopted), should be financed through increases in Medicare premiums.

Third, to make the program fairer to poor, elderly Americans, the amount they pay yearly in premiums should be related to their incomes. A portion of premiums should be paid through a five percent surcharge on the income taxes of the 40 percent of aged Americans who pay such taxes. Revenues from this surcharge should offset part of the premiums charged for Medicare coverage.

Fourth, the Medicare program should cover a well-defined package of basic preventive services without coinsurance or deductibles. It should also cover extended long-term care services and home health care services. Because of their high-costs, expanded long-term care benefits should be phased in over a ten-year period, starting in 1990, when current efforts to reduce federal deficits have achieved results.

Fifth, to make physician services cheaper and provider compensation fairer, Medicare should change the way it pays physicians by implementing a fee schedule based on the relative value of their services. Medicare should also rely more on prepaid health care arrangements such as health maintenance organizations. These reforms should be accompanied by the requirement that physicians accept Medicare payments as compensation in full, so that patients will know in advance how much they are going to be charged.

These reforms comprise only a sample of the more than 40 specific recommendations contained in our forthcoming article, the "The Future of Medicare" (New England Journal of Medicine, March 13, 1986), and our upcoming monograph, Medicare: Coming of Age. Many of our proposed reforms (increased reliance on premiums, catastrophic coverage, merger of Parts A and B of Medicare) could be accomplished within the next five years at little or no cost to the Medicare program. For other proposals, it would be wiser to wait until 1990 or 1991, so that fiscal and technical issues can be resolved.

As the cost table in your packet makes clear, we estimate that, excluding long-term care, our proposals would add little, if anything, to aggregate Medicare expenditures by the year 2000. However, our long-term care reforms would increase federal expenditures by nearly \$50 billion, of which \$35 billion would offset expenditures made by other governmental and private parties. We do not propose such substantial new expenditures lightly. Our recommendations reflect our conviction that, given the rapid aging of our population, Americans will pay heavily for long-term care over the next 15 years, regardless of what Medicare or the federal government do. We feel that universal, federally sponsored insurance for long-term care expenses is the only practical, efficient and equitable method for protecting elderly Americans against the looming expenses of long-term care.

It is clearly imperative to consider costs in assessing the merits of this package of proposals. Yet, it is just as essential to consider other factors that have received less attention in the current fiscal and political climate. Given the current drift of Medicare policy, what kind of protection against the financial costs of illness will elderly Americans have in the year 2000? What kind of access will they have to services? How will we care for the growing numbers of frail elderly who can no longer live alone?

These questions deserve study now, if only because changes in policy should be informed by long-range considerations. In 1965 the political process produced a Medicare program that, for all its current failings, represented a triumph of humane public policy. It is now time to correct those failings so that the program can meet the challenges of the next twenty years.

Mr. PEPPER. Well, thank you very much, Dr. Blumenthal. As I said, we hope to have the privilege of conferring with you three gentlemen and others in an effort to get something going in this field of protecting the elderly and eventually all of the people against catastrophic illness. Because we know that today serious illness can deprive most people of all of the savings that they have, sometimes even their home.

I had lunch yesterday with the head of one of the major insurance companies, and they are very actively moving into this general field. They are responding, I think, to the market needs of which you gentlemen have spoken.

Your study, Dr. Blumenthal, indicated and Mr. Califano has indicated that the American people want something done about providing a better medical system to the people of this country.

A lady sat by my desk a little bit ago. She said, "Mr. Pepper, if you would look at my eyeballs, you will see that they have already turned yellow. I have a liver disease. I have three children, and I am supporting my mother. The doctors tell me that if I do not have a transplant in the next 6 or 9 months, that I will be dead in the next 12 months."

She said, "I have been able to raise \$45,000 from kind people to help me have an operation, but the hospitals tell me that it will probably cost \$150,000, and maybe even more before I get the services that I need."

She said, "Can you help me?" Well, at that time, I asked the head of OMB who knew more about the Government, I thought,

than anybody. And he said, "I do not know of any Federal aid that is available." He checked up on it and called me back and said, "I do not know of any Federal aid available."

Now it was a miracle almost. I was of a little help to her, but other people have helped, and finally she had a liver donated by somebody in Texas and she had the transplant operation at one of the big hospitals in Boston. They did the operation for less than what they usually charged for it, when she had an opportunity to get a transplant.

Now she is trying to raise \$15,000 a year that she says it costs to try to rebut and resist the effort of the body to reject the transplant.

And when I had this experience, I thought about thousands of other people all around the country that needed a transplant or something. They were probably not going to be as lucky as this lady was, to get generous people to come in and help her, and hospitals that will make the concession this one did in Boston.

A lady sat opposite of me at a dinner in Miami not long ago. She said, "Mr. Pepper, I am an obstetrician by profession." She said, "You would be surprised to know how many children are born with defects which if properly attended to by competent people could be alleviated. And those children will grow up to be relatively normal people." But she said, "Most of the mothers of these children are poor. They do not even know where to find the hospital that can do the operation, and they say that they do not have the money to pay for it. The result is that the children grow up with the abnormalities-restrained and strangled by their abnormalities that came with them at birth."

So that is the reason why the American people want this. They all know, they have had experiences in their families and in their community, and among their friends. I think that human life is a gift of God and sacred, and one man's life is as valuable as another's. And one man just because he is rich should not be permitted to live, and the other one because he is poor should not be permitted to die.

And that is basically what it comes down to. This man here is a great lawyer, and if I may add a very prosperous lawyer, yet here he is spending his time and efforts trying as he did while he was Secretary of Health, Education, and Welfare, trying to help other people.

Every mother is not as fortunate as his mother was in having somebody to keep her out of a hospital, and give her the care that she needed. Eventually, of course, we are talking about a system of insurance which would be primarily developed by private enterprise. I would like to see the Government contract maybe with insurance companies or others, HMO's or other responsible groups if they felt that they could get a good deal out of it.

But I am just wondering. Obviously, the Government is going to have to supplement. If the poor are covered, they cannot pay the premium that has to be paid in order to get the care that they need, comprehensive care. So obviously, I assume that the Federal and the State governments or some other agency are going to have to share part of the cost.

Do you know of anybody in the country, has your study gone far enough into that field, is there anybody making a study of the kind of system that we ought to have? Maybe Mr. Califano spelled it out here in his book. I shall certainly read it with avid pleasure.

But I asked a friend of mine one time. And he said, "Well, the Ford Foundation is doing something like that." And he said, "Dr. Shapiro who used to be head of Du Pont, you know, he is now chairman of a committee set up by the Ford Foundation."

And we had Dr. Shapiro down for lunch and discussed the matter with him. And he has got another year substantially of his committee.

Do either you, Mr. Califano, or either one of you know of any institution or anybody that is making a study upon which we can begin to build plans for such legislation?

Mr. CALIFANO. Mr. Chairman, I do not know about a study, but let me make one comment. At Chrysler, where I chair a committee on health care costs, as you know, we have just completed an analysis of our 1984 health data. And what it showed was that 3.4 percent of our employees accounted for 45 percent of our health care dollars.

And as we have broken that down, we have found a phenomenal amount of hospital care that should have been done in the home. They were typical situations, a terminally ill person goes to the hospital, and spends 6, 8, or 10 weeks in the hospital and dies with no treatment, obviously sent there to die. It could have been handled much more humanely at home with hospice aids.

In other situations, some of our chronically ill people are periodically put into the hospital. And where that has led us is to change our plan, and I think that this is where the big push will come fast, not from insurance companies, but direct contracts between large corporate employers and nursing services adding flexibility into their plans.

As they become more involved in requiring second opinions before people can go to the hospital, you cannot go to the hospital under the Chrysler plan and be paid any more without a second opinion. The number of days are set in advance. We have doctors reviewing the length of stay.

But as part of that plan, we are going to provide home health care. And I think that the large corporate employers—what is so topsy-tervy about what Medicare is doing is here in the private sector, the large corporate employers with big health dollars at stake, looking at this and saying we can provide better quality care more humanely and save dollars. And in that area, I think that you are going to see a big change. Medicare is going in exactly the opposite direction.

Mr. WYDEN. Senator.

Mr. PEPPER. Yes.

Mr. WYDEN. I appreciate you yielding just for one question.

Mr. Califano, I understand that one of the reasons that Chrysler has been successful in holding down their costs is the approach that involves the preferred provider organization concept, the PPO. I know that Senator Pepper has been very supportive of that as well, and we would be interested in your thoughts on whether the

Federal Government would be wise to try some sort of PPO kind of approach say with Medicare.

Mr. CALIFANO. I think that the Federal Government should get a wider variety of people providing Medicare, and I think that they should use PPO's as well as HMO's. Let me give Chrysler as an example; we are even now looking at this possibility. We think that we can provide the Medicare benefits to our employees at a far lower cost than Medicare is providing them.

We would be willing to make the same contract with Medicare as they make with a HMO. For 95 percent of what it would otherwise cost Medicare, we will provide the same care. And we will go at risk. If it costs more, we will eat it. If it costs less, the money would go to Chrysler. I think that is another thing that Medicare should try and do.

One more example. In Michigan, Chrysler put in utilization screens, particularly hospitalization screens—no admission to a hospital in nonmaternity and nonemergency cases without a prior second opinion. The premiums for Blue Cross and Blue Shield of Michigan for Chrysler-salaried employees dropped below those of the HMO's by 10 to 25 percent.

So we went to the HMO's this year and told them that they had to lower their prices. I think that the competition out there is healthy. And I think that if we do not take the benefits of that efficiency and provide the kind of care that you are talking about today, that will be a tragedy for our people.

Because we have the ability in this country to have a health care system efficient enough to give care to everybody including those 33 million people who have no health insurance, and the people who cannot get home health care because of shortsighted policies.

Mr. PEPPER. I think that Chrysler has done a marvelous job, Mr. Califano. The experimentation that you are doing is of value to the rest of the country, and also for the practical effect that it is having in affording medical care to people in such an excellent way.

Dr. Blumenthal, do you have anything further to say?

Dr. BLUMENTHAL. I would just like to make one comment. I am somewhat familiar with the Chrysler experience, and I agree that they have done a remarkable job in reducing their health care expenditures. And I am also sensitive to the comments that you made, Mr. Chairman, and that Mr. Califano has made about those people who are not protected who cannot negotiate cut-rate deals on their own behalf.

And I think that as competition spreads in the health care sector, and as the health care sector, and as the health care sector is sort of blown wide open, to this revolution in organization that we are now seeing, the safety nets that we have constructed to protect those who are least able are going to be eroded rapidly unless there is very assertive Government action to prepare them.

I think that it is an inevitable and foreseeable consequence. I think that we have kind of right now a beggar thy neighbor atmosphere prevailing in the health care sector in which everyone is out for themselves. Business appropriately is trying to reduce its health care costs. Labor will soon catch on to that, I am sure, if they have not already.

But in the process, the arrangement that allowed the non sick and the wealthy to help subsidize the care of the sick and the poor in the private sector are going into the circular file, and they are just not going to be available any more.

One of the reasons why people in the academic world perhaps have not proposed loud and clear solutions to this is that the impression that you get reading the Washington Post daily and listening to the news is that there are relatively few people down here such as yourself, Mr. Chairman, who are listening to the message that Government needs to step in and do something even at the cost of providing some fiscal support. And I think that that is going to be the challenge for the health care system in the next decade.

Mr. PEPPER. Doctor, I was at a hearing of an elderly audience in California in the convention center out there a couple of years ago. And all over that room, there were big signs up, why do you not have National Health Insurance? National Health Insurance. Not long after that I was at a hearing in Philadelphia, and all over the room there were people with placards and banners and signs that said, why do you not have National Health Insurance?

Not long after that, I saw Senator Ted Kennedy. And I said, "Ted, it may well be that we are getting behind the people here, in Washington. Maybe they are ahead of us. And I think that we ought to be more energetic in getting something done."

So this committee is trying to do what it can to get something started. We have introduced some legislation, and we are going to submit it to you for criticism and improvement. And I would like to follow much of what Mr. Califano's company has exhibited. Rather than a bureaucratic system set up by the Government, let us have the marketplace provide competition, so to bring the costs down in a proper way.

Down home where we have HMO's, already I am beginning to hear people say, "I like that one better than I do this one. It is giving me better care. I like the way that they look after me," and this, that, and the other.

Insurance companies are moving in. And maybe we can see the time when the Government will just let the companies come up with an insurance plan, and all they will say is is it a good system, is it a good plan, is it fair. The Government would see to it that it was properly administered, so that it would be fair to the people. And then if the Government does have to add to the contribution, it will help them to run the system.

And in that way, we would encourage the competitive enterprise to have the maximum share. I believe that the insurance companies now are very much aware. As one of the big companies in the nation told me yesterday, "We felt like we were getting behind in this picture, but we are moving forward now."

Mr. WYDEN. Senator, would you yield for just a moment?

Mr. PEPPER. Now then, I am sorry to take so much time.

Mr. WYDEN. No, no. I just want to support what you are saying. And I think that there are some grounds for agreement here. I think that what Senator Pepper has said is yes, we ought to have more choices in terms of health care services, but we want to make sure that the Government still maintains a vigorous role to protect quality.

Mr. PEPPER. That is right.

Mr. WYDEN. So that low income people are protected. And I think that is something that you would agree on as well. And we are going to make sure that we have with this budget a little more balance, so it is just not all stacked on the military end, and low-income people are again cut.

So I think that with Senator Pepper's approach and with a strong emphasis on quality, I think that we can have some agreement between you two and have more choices for consumers.

Dr. BLUMENTHAL. I hope so.

Mr. PEPPER. Thank you, gentlemen, very much for your very valuable contribution. We are going to show our bill to you, Joe, and let you criticize it. And I am going to read your book. Thank you very much. Now I have go again. My distinguished colleague, the Honorable Ron Wyden, will preside. We have one panel of two witnesses to be heard. Mr. Wyden, if you please. Thank you all very much.

Mr. WYDEN. Well, we are very happy to have our final panel, and a very distinguished panel. Mr. Jack Guildroy, member of the American Association of Retired Persons; and Ms. Marilyn Field, the Executive Director for Utilization and Benefits Management for the Blue Cross and Blue Shield Association.

Because the time is late, and I know that you all have been waiting, and I just feel that I am going to get summoned again as well, if you all could just summarize your principal concerns for the subcommittee. We will make a copy of your prepared remarks a part of our record in their entirety, and then perhaps we will have time for a few questions. We appreciate your patience. And why do we not begin first if we might with you, Mr. Guildroy.

PANEL THREE—RECOMMENDATIONS FOR REFORM: CONSISTING OF JACK GUILDROY, MEMBER, AMERICAN ASSOCIATION OF RETIRED PERSONS, NATIONAL LEGISLATIVE COUNCIL, PORT WASHINGTON, NY; AND MARILYN FIELD, EXECUTIVE DIRECTOR, UTILIZATION AND BENEFITS MANAGEMENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION, WASHINGTON, DC

STATEMENT OF JACK GUILDROY

Mr. GUILDROY. Thank you very much. My name is Jack Guildroy. I am a member of the American Association of Retired Persons' National Legislative Council. And at my left is Shelah Leader of our legislative staff. And on behalf of the 22 million members of AARP, I am honored to share with you our concerns about home health care today, and our hopes for home health care in the future.

My prepared testimony focuses in detail on problems and needed remedies in the provision of home health care, and I am sure that it will become part of the record. And my oral statement briefly touches on some aspects of home health care as a part of long-term care.

We think that there are two crisis situations today in the availability and delivery of home health care services to older Americans. These crises arise from somewhat different causes and they require different remedies. First, AARP believes that there is a

crisis in the availability of post-acute care services covered by Medicare, Part A. There is ample evidence of an increased need for skilled nursing care and home health care services among recently discharged hospital patients.

The average length of hospital stay has dropped in response to the Medicare prospective payment system. And as a result, older Americans are leaving hospitals quicker and sicker than in the past, too often with no place to go, entering a no care zone where frail patients are left to fend for themselves.

Their need for transitional care should be covered by home health benefits under Part A. But these benefits are becoming harder to get. HCFA has been using regulatory mechanisms to arbitrarily and capriciously restrict the statutory provision of access to care, to reduce the scope and duration of provided services, and to deny coverage for needed services. Something must be done to correct these regulatory abuses.

Now the problems faced by chronically ill persons and their families are somewhat different. Medicare does not cover long-term care for the frail, disabled, and mentally ill whether that care is provided at home or in an institution. Consequently, growing numbers of frail dependent persons must incur catastrophically high out of pocket costs for long-term care services.

Only after they have become paupers will Government, through the Medicaid program, help defray the cost of their care. One solution to these catastrophic health costs is long-term care insurance providing stop loss against out of pocket expenses. To date, private long-term insurance is not widely available.

AARP commends Senator Pepper for his leadership in proposing an enhanced long-term care protection in exchange for an additional Medicare premium. We at AARP would be happy to work with Senator Pepper and members of the subcommittee in developing public policy in response to this immense problem.

Another problem in the field of long-term care is the lack of uniform and meaningful standards of care, monitoring and enforcement of quality of service, and consumer protection. There is great potential for fraud and abuse in this rapidly growing service sector. Expanding the PRO's scope of work to include home health agencies is a crucial element to the development of the continuum of care.

Furthermore, chronically ill and dependent persons need a broad array of planned, supervised, and coordinated services. Several demonstration projects show great promise in delivering comprehensive and affordable care to non-institutionalized persons. And these creative programs deserve more encouragement and support rather than bureaucratic red tape and crippling restrictions.

We have submitted for your record more detailed testimony. We would be happy to provide you with any additional information that you may need. And thank you again.

[The prepared statement of Mr. Guildroy follows:]

PREPARED STATEMENT OF JACK GUILDROY, MEMBER, AMERICAN
ASSOCIATION OF RETIRED PERSONS, NATIONAL LEGISLATIVE COUNCIL,
PORT WASHINGTON, NY

Senator Pepper, and members of the Committee, my name is Jack Guildroy. I am a member of the American Association of Retired Persons' National Legislative Council. I am honored to be here on behalf of the 22 million members of AARP to talk about the need for improved home health care services.

Improved access to comprehensive home health services are desperately needed for both post acute care by persons recently discharged from hospital and by those suffering from chronic illness and disability.

Those who need post-hospital transition care are being denied access to their Medicare benefits through a series of regulatory actions by HCFA and its fiscal intermediaries. This constitutes regulatory denial of a statutory benefit. In this case, regulatory relief may be the answer.

Chronically ill and disabled people and their families face catastrophic costs for long term care at home and in institutions. The price of care is pauperization. The answer for them is improved coordination of a range of services and the financial protection afforded by long term care insurance.

Any home health care policy must address the pressing needs of both the acutely ill and the frail and disabled.

Need for Home Health

Because Medicare expenditures for home health care comprise less than 3% of total outlays, little Congressional attention has been focused on this vital Medicare benefit. In fact, demographic trends and changes in Medicare Part A reimbursement methods have combined to make home health services increasingly important to people age sixty-five and older.

Specifically, the size of the frail, chronically ill, and disabled population is rapidly growing. According to the 1982 National Long Term Care Survey, 19% of those sixty-five and older have some degree of disability, while 4% of non-institutionalized older persons are severely disabled. Disability rates increase markedly with age, so that those who are age 85 and older are four times more likely to be disabled than younger Medicare enrollees. And, this age group is the fastest growing segment of our population. Consequently, the societal need for assistance in activities of daily living by disabled persons will increase rapidly.

As a result of this fact, the demand for home health services is growing rapidly today and will continue to grow in coming years. According to Bishop and Stassen's study in the Pride Institute Journal of Winter, 1986, growth in the number of persons served is the largest contributor to home health care expenditures. The rate of utilization tripled between 1974 and 1982. Another contributing factor in the growing need for home health services is the pressure for early hospital discharge under the prospective payment system (PPS) inaugurated in 1983.

Van Gelder and Bernstein report in the same Pride Institute Journal that in fiscal year 1984, discharges from PPS hospitals to home health care were 3 1/2 times higher than the rate of discharge to home care from non-PPS hospitals. The authors report that all of the studies by the U.S. Department of Health and Human Services find that the rate of discharge to home care rose sharply after PPS was implemented; that older patients are being discharged earlier and sicker; and that home health care providers are giving more skilled and intensive care to clients now than they were before PPS began.

These formal findings are corroborated by informal surveys of providers, by testimony submitted to Congress, and by letters we have received from distraught and angry members who need and cannot obtain home care. Our members write heart-wrenching letters about being forcibly discharged from hospitals while still needing extensive care. Unmarried older persons are being

sent home from hospitals despite the fact that they are too ill to care for themselves. Many of our letters are from the spouses and children of recently hospitalized people whose need for physical and medical care exceeds the time, strength, and skill of family members into whose care they are discharged. In sum, the demand for home health care services is being stimulated by the growing numbers of acutely ill people who are being denied post-acute transition care in hospitals.

Inadequate Benefits

While the need for home health care is growing for both chronically and acutely ill persons, the Medicare home health benefit is both inadequate and often unavailable.

Current problems in the scope and structure of Medicare's home health benefit can be attributed to several causes: determination of eligibility, scope and duration of services, and lack of protection for consumers.

Eligibility: Although the requirement of prior hospitalization was eliminated in 1981, eligibility for home health benefits under Medicare is still linked to acute, temporary illness rather than the need for chronic care. To be eligible for this Medicare benefit, individuals must be certified by a physician to need part-time or intermittent skilled nursing care.

In an effort to curtail use of this benefit, HCFA has been formally and informally adopting increasingly stringent definitions of "part-time" and "intermittent" care.

Additionally, the definition of being "home bound" - another eligibility criterion - has also been subject to varying and arbitrary interpretations.

For example, in 1975, HCFA's Health Insurance Manual-13, section 3119.6 defined intermittent or part-time care to average 20 hours or less a week for up to 100 hours a month. By 1981, HCFA's Home Health Agency Manual Transmittal No. 127 limited care to 1-2 hours a day, 2-3 times a week. Providers had to justify any additional levels of care. For the very ill, HCFA permitted

"medically reasonable and necessary" aide services on a daily basis for no more than 2-3 weeks. A year later, HCFA's Transmittal No. 137 provided a guideline of nine hours a week.

Several problems have been identified by providers and beneficiaries. Fiscal intermediaries vary in their interpretation of "part-time" care and retroactive denials of coverage are not uncommon. In some states, receipt of 3-5 care days a week is considered to be daily care and thus ineligible. In other states, clients may not receive more than one visit a day, even if the purpose of the visits differs.

Variations in the interpretation of "home bound" have also resulted in denials of eligibility to those in need of care. Under current guidance (Health Insurance Manual-11, Section 208.4), a person must be normally unable to leave home except for infrequent periods of relatively short duration. The imprecision of these words has led to absurd situations where people have been denied coverage because they left home to receive chemotherapy.

The GAO has repeatedly criticized the homebound requirement as unduly restrictive, yet it is retained. Consequently, ambulatory people who can't dress, bathe or prepare meals can be denied care. Additionally, improvement in mobility - a goal of home health services - could jeopardize receipt of needed home services.

Finally, if all one needs initially is occupational therapy, eligibility will be denied. Yet, one can continue to receive such therapy after skilled nursing care is no longer needed.

Because of these and other arbitrary and capricious interpretations of eligibility criteria, untold millions of older Americans may be denied access to necessary care. HCFA data show that rates of denial for home health care claims are increasing. Between FY 1979 and 1983, denials of Part A home health bills rose from 2.8% to 3.7%. Between FY 1982 and 1983, the number of these denial notices sent to beneficiaries increased 8.9%.

Yet, this may only be the tip of the iceberg of unmet or denied care. Since providers are now liable for the cost of care provided to persons later determined to be ineligible, home care agencies may be refusing service to doubtful cases. We have no data on the extent of unmet need for post acute care service, but present conditions lead one to assume that the problem is serious.

Furthermore, we don't know the extent to which beneficiaries and their families are directly paying for needed services to supplement the benefits provided under Medicare. There is anecdotal evidence that when families do supplement the home care benefit, they may thereby lose eligibility for services. In Connecticut, for example, the LAMP program (Legal Assistance to Medicare Patients) reports that if family members provide care to people receiving home health services, the client may be found to need more than "part-time" or "intermittent" care and then be denied all home health care services!

Another weakness of current eligibility standards is that the social circumstances of patients are not considered. It is now commonplace for weak, ill people to be sent home from hospitals when there is no family member to care for them. Unless they need skilled nursing care, they cannot receive home health services despite their obvious inability to care for themselves.

Scope of Services

As we noted, the Medicare home care benefit offers both too little volume of care for many people and is unduly geared to meet an acute medical need. The growing cohort of frail and mentally disabled people with long term needs for care -- both skilled and personal -- is not being addressed by Medicare. We lack a long term care system encompassing medical, social, and personal care services provided in a variety of community, home-based, and institutional settings. For example, Medicare does nothing for the Alzheimer's patient whose family is struggling valiantly to avoid institutionalization.

The primary source today of home-based long term services for the elderly is family members. These free services are supplemented by the Older Americans Act and Medicaid. Yet, Medicaid eligibility standards vary enormously, as does the range of provided services. Only eight states offer personal care services to the categorically needy; sixteen states offer this service to both the medically and categorically needy. Only two states offer unlimited service. The fourteen states which require prior authorization for part-time nursing care account for 83% of Medicaid expenditures for that service. The thirteen states requiring prior authorization for aide services account for 83% of these expenditures. Five states do not provide homemaker services.

This patchwork of rules and coverage is confusing and inconsistent. The unavailability of requisite home-based services forces untold numbers of older Americans to jeopardize their health; pay out-of-pocket for needed but uncovered services; and finally to enter an institution.

Chronically ill, frail, and/or disabled people cannot obtain home health benefits under Medicare. To obtain these services under Medicaid, older Americans must spend down in order to meet eligibility criteria. We know the financial catastrophe faced by those who enter nursing homes. Most private paying residents are pauperized within a short time from entry. This committee found that nearly half of unmarried residents age 75 and over are pauperized within thirteen weeks of entry. Three-fourths of these residents are impoverished within a year. Older Americans desperately need financial protection against the catastrophic costs of long term care. Yet, long term care insurance is not readily available from private insurers and public policy has failed to remedy this problem.

Some estimate that as many as 20% of nursing home residents could live at home with community-based services. When needed services are unavailable, frail elderly persons are forced into institutions where they face immediate and crushing costs. At present, about half of all nursing home costs are paid directly by consumers.

Provider Qualifications

Another problem in the area of home health is the absence of quality standards for providers. This essential service sector is largely unregulated and opportunities for abuse and substandard care abound. Consumers who do obtain home health services are generally at the mercy of strangers who may be untrained for their duties, unsupervised, incompetent and/or dishonest. The home care field is growing and changing rapidly; between 1981 and 1985, there was a 74% increase in the number of Medicare certified home health agencies. The greatest growth has been among proprietary agencies, largely in response to the 1980 Omnibus Reconciliation Act which permitted Medicare certification of proprietary agencies in states without licensing laws.

Licensing and certification standards vary greatly among our states. While HCFA is primarily concerned about reimbursements, hardly anyone is formally charged with assuring access to and quality of care. There are few avenues of recourse open to persons inappropriately denied care or given substandard care. Indeed, in some instances there may not be a standard of care. Caveat Eaptor is an irresponsible guide to our most vulnerable citizens. Consumer protection must be built into our home health care programs.

NEEDED SOLUTIONS:

AARP believes this situation represents a failure of public policy. A crisis in care confronts Americans today -- a crisis with serious health, social, and financial costs. American families desperately need accessible, high quality, comprehensive, coordinated post acute and long term care home health benefits. Home health services should combine the following features:

- it should cover both acute and chronic conditions;
- provide a full array of well trained and supervised skilled, personal, and homemaker services in the home as well as in an institution;

- when appropriate be linked to a hospital discharge planning process;
- encourage participation by family members, friends, and community volunteers;
- cap out of pocket expenditures so that people are not pauperized by their need for long-term care;
- be based on the insurance principle of shared risk and predictable individual costs;
- provide for data collection and evaluation to measure both access to care and quality of services delivered;
- meet reasonable and uniform quality standards; and
- include consumer protection and participation.

To achieve these goals, we recommend that Congress take steps to ensure improved access to home health benefits under Medicare Part A. Improper regulatory denial of statutory benefits must be stopped. Specific remedies for this problem could include: requiring discharge planning by hospitals; continuing the waiver of liability for home health providers; requiring HCFA to publish clarifying guidelines and to limit fiscal intermediaries' discretion; and including home health within the PRO's scope of work.

In addition, affordable and adequate long term care insurance must become more readily available. AARP is open to the notion of an increased Medicare premium in exchange for true stop loss protection against the costs of long term care. We are also exploring the possibility of private sector long term care insurance.

We further recommend prospective payment for a case managed system of long term care. Community based care will require a continuing combination of public and private sector funding. AARP supports the Medicaid 2176 Waiver program and deplores restrictive regulations which serve to hamper its operation. We recognize that we have a long way to go before existing services meet these criteria. The task is large; the need is great. We cannot afford to wait in developing the solutions.

Thank you, Mr. Chairman, for this opportunity to state the Association's views on these very important issues.

Mr. WYDEN. Thank you very much, Mr. Guildroy, for an excellent presentation, and we will have some questions here momentarily.

Ms. Field, we welcome you to the subcommittee, and look forward to any presentation that you care to make. And we will make a copy of your prepared remarks a part of the record. And if you could just highlight your principal concerns, that would be very helpful.

STATEMENT OF MARILYN FIELD

Ms. FIELD. Thank you. What I primarily want to do is summarize some of our experience in the private sector, rather than the public sector, with providing health benefits coverage for nearly 80 million Americans. This includes nearly 10 million Americans covered by Medicare supplemental policies. And we also have our experience as medicare intermediaries and carriers.

We suggest that the committee look at home care in the context of a broad program of benefits management. It is not an isolated program. Its management is not just a matter of benefit design and what is in the law—although as you have heard here today, there is a lot of interpretation of the medicare home health benefit that could use clarification, rules and guidance.

What Blue Cross and Blue Shield plans tried to do in home care benefits development is use a cautious approach to test new services and examine how the whole array of benefits management tools fit together for home health care. For example, in our health benefit programs, we use a broad range of cost containment tools: negotiated provider payment; prospective, concurrent, and retrospective utilization review; alternatives in patient care; provider audits; second surgical opinions. These types of strategies have worked well. In 1984 alone, we saw more than \$6 billion worth of savings for Blue Cross and Blue Shield subscribers. And we have

just refunded nearly \$746 million, for Federal employees that we cover.

We have also worked home care benefits and benefits management tools into alternative delivery systems. Blue Cross and Blue Shield sponsor 77 HMO's and 48 PRO's.

We are taking the experience in managing many other kinds of benefits and applying it to home care. If home care is put in the context of managed utilization review, benefit design, quality monitoring, then we think that it can be a cost effective substitute for more expensive care. It can also be a more comfortable and humane way of providing care.

I will not review in any detail the types of techniques that plans have used in managing home care benefits. Those are in our statement for the record. They include negotiated arrangements with home care providers, selective contracting, pre-authorization of treatment in some instances, approval of treatment plans, certain constraints on the utilization of services.

Plans have found considerable cost savings. Blue Cross and Blue Shield of Connecticut, for example, estimated in 1985 alone nearly \$6 million worth of savings just from the substitution of home care for institutional care. That was an average of \$3000 per home care patient. The Blue Cross and Blue Shield of Rhode Island estimated savings of \$3 million.

One of the more interesting ways that plans have been expanding home care coverage is not through the routine offering of coverage, that is, just adding a new benefit. Rather, plans are applying home care as part of the individual management of catastrophic and chronic illnesses. We are looking at specific cases, identifying patients who are likely to be in need of very expensive and very complex care for a considerable period of time. We look at these people very individually and consider alternative treatment plans. What can be done besides keeping them in the hospital?

We are finding that there are often a variety of options for home care that can be carefully worked out and negotiated with the family, the providers, the provider's physician, the home care agency, and suppliers. When you work out in detail a treatment plan of alternatives to institutional care, you can often make a strong case for significant savings. And the care can be much more humane, comfortable and acceptable for patients and families.

Now this is an intensive kind of activity. It is most effective in high cost cases, and it is a way of solving a traditional Coverage dilemma: You see the need for coverage, you see the people who need care. On the other hand, once you scrutinize benefit use, you also see some care that is not necessary.

We have seen the statistics on unnecessary days of hospital care. We have seen the wide variations in surgical rates across the country, and the implication, given no evidence of greatly different outcomes, that there is a lot here that is unnecessary.

High cost cases is an attempt to take a benefit and apply it where it is needed most without running the risk of increasing ill-considered and ill-advised use.

We believe that that kind of focused direction is going to allow us to expand the range of benefits. We have got pilot programs to cover special populations like ventilator dependent children. We

are looking at an array of infusion therapies, for example, the chemotherapy that was mentioned earlier.

To summarize, we are cautiously optimistic about the opportunities for expanded use of home care as an integral part of care for chronic conditions. We perceive further expansion of home care benefits in Blue Cross and Blue Shield HMO's, and PPO's and managed care programs. In addition, we are looking at the development of long-term care insurance.

I would like to add two final statements. First, if a service is medically appropriate to provide in the home, care at home helps avoid the need for care in an institution, and if effective benefit design and utilization management are provided, then home care can be more comfortable and more economical than institutional care.

Second, home care is a rapidly changing area. You have heard a lot about that today. Coverage cannot be static. It needs frequent reassessment in the context, we think, of experimentation and deliberate assessment of what the implications of this new kind of service are and how you manage it so that you get the most out of the home care benefit.

We hope that these observations will be useful to you, and we would be glad to work with the subcommittee as you pursue this important topic.

[The prepared statement of Ms. Field follows:]

PREPARED STATEMENT OF MARILYN FIELD, EXECUTIVE DIRECTOR,
UTILIZATION AND BENEFITS MANAGEMENT DEPARTMENT, BLUE CROSS
AND BLUE SHIELD ASSOCIATION

Mr. Chairman and Members of the Subcommittee, I am Marilyn Field, Executive Director of Utilization and Benefits Management for the Blue Cross and Blue Shield Association. The Association is the national coordinating organization for the 85 Blue Cross and Blue Shield Plans. Plans underwrite or administer health benefits programs for over 100 million Americans, including about 9½ million elderly Americans enrolled in Medicare supplemental programs. In addition, the Association and Plans serve the elderly as Medicare intermediaries and carriers responsible for the day-to-day administration of this important program. Thus we are extensively involved in assuring that the elderly have access to a broad array of affordable health care benefits.

Our experience in managing health benefits programs effectively in the private sector may be helpful to the Subcommittee as you consider the role of home care in a comprehensive program of care for long term illnesses. Some Blue Cross and Blue Shield Plans have offered home health benefits for as long as 30 years. In 1974, the Blue Cross Association issued a model benefit description with a policy statement encouraging Plans to offer home care coverage. Today, virtually all Plans offer such coverage.

Initially, Blue Cross and Blue Shield Plans saw routine home care benefits as a way to shorten hospitalization for certain patients recovering from acute illnesses and injuries. More recently, Plans have realized that some patients with catastrophic injuries and chronic conditions can also be cared for more humanely and more economically at home. These latter patients often use very expensive high technology services only recently available in home settings, and benefit coverage may be individually designed to meet their special needs. The expanded application of home care benefits reflects new technological developments, growing acceptance by consumers, the maturing of home care providers, and not least, pressure to reduce health care costs, especially costs for expensive hospital care. Because they are locally based and have close working relationships with providers, Blue Cross and Blue Shield Plans have been well situated to test coverage of new home care services and to learn how to manage the cost of these services. The development and management of home care coverage has been characterized by deliberate experimentation and gradual evolution.

Blue Cross and Blue Shield Plans have had little or no direct involvement in providing benefits for custodial or supportive, as distinct from therapeutic or rehabilitative, home

care for those with long term conditions. Rather, benefits are provided for acute care services needed by patients with long-term problems such as cancer, diabetes and its complications, orthopedic problems, cardiovascular conditions such as stroke, Alzheimer's disease, severe accidents, and respiratory conditions such as emphysema. We also are exploring the potential role of home care in developing long term care insurance products.

Cost Containment Strategies and Home Care

Blue Cross and Blue Shield Plans have been leaders in developing cost containment strategies. These strategies included early adoption of negotiated provider payment limits, technology assessment, retrospective and concurrent hospital utilization review, provider audits, coverage of alternatives to expensive inpatient hospital care, second surgical opinions and pre-admission review. Cost containment strategies such as these saved our subscribers over \$6 billion in 1984, the latest year for which data are available. As evidence of the cost effectiveness of these practices, the Blue Cross and Blue Shield Federal Employee Program will refund \$746 million in 1985 premiums to the government and federal workers and retirees. Alternate delivery systems are also an important component of Plan cost containment strategies. Plans own or operate 77 HMOs and 48 Preferred Provider products (PPPs) covering 5 million subscribers. Plans also are leaders in offering managed care and innovative benefits design. New comprehensive managed care programs cover another 5 million subscribers.

The experience accumulated in provider payment, utilization review and benefit design has been applied to Plan management of home care benefits. We believe coverage of home health care can be cost effective if it is part of a broader program of benefits management that assesses individual medical need and coverage options. In such a program, home care can be a more economical substitute for institutional care.

To make home care available at a reasonable price, Plans use their long experience in selecting and contracting with community providers. A number of Plans pay home health agencies on a prospective cost basis or negotiated price basis. Some Plans also are testing per diem payment for hospice care.

Utilization review contributes to effective application of home care benefits in several ways. During preadmission and concurrent hospital review, Plans can identify early those patients for whom home care is or will be appropriate. Plans also work with hospital discharge planners to coordinate the transition from hospital to home.

At least 20 Plans now require pre-authorization in some cases for home health services. Most Plans also require physician-developed treatment plans for patients, and many have devised utilization controls for certain services and supplies. Contractual relations with

home health providers support these utilization controls and also provide a foundation for quality monitoring. For example, requirements for accreditation, site visits and record audits may be part of the contracting process.

Several Plans permit subscribers and their physicians to substitute home care benefits for covered days of hospital care. For instance, where medically appropriate, a subscriber may receive three home-care visits for each unused hospital day up to the maximum number of hospital days provided under the subscriber's policy. Such flexible arrangements permit our subscribers to receive extensive care at home while avoiding the stress of hospitalization. Subscriber deductibles, minimal copayments, and maximum visit limits may also play a role in benefit design.

Cost savings from managed home care can be considerable. For example, the Connecticut Blue Cross and Blue Shield Plan estimated 1985 savings of \$5.8 million due to the substitution of home care for hospital care, an average savings of \$2,900 per home-care patient. The Plan spent an average of \$49.60 for each home care day compared to \$561 per hospital day. Blue Cross and Blue Shield of Rhode Island estimated a 1985 savings of \$3 million from the use of home care. Blue Cross and Blue Shield of North Dakota estimated it saved its subscribers \$727,000 by reducing hospital days through home care.

Individual Benefits Management and Home Care

Plans are increasingly finding home care to be particularly important for the individual benefits management of catastrophic and chronic illnesses. Individual benefits management is a comparatively new program. It is an organized effort to identify high cost patients early, develop alternative treatment plans and to provide and manage benefits for these patients as cost-effectively as possible. Plans work closely with hospital discharge planners and home health providers to arrange transfers from inpatient settings and to assure that necessary and appropriate home care is provided. Some Plans make case-by-case decisions about arranging for home care that is beyond the normal scope of coverage, but nevertheless is effective in avoiding more costly care. Home care also may considerably improve the quality of life for patients and their families, although serious illness certainly will never be stress free.

Home Care in Alternate Delivery Systems

Many Plan HMOs include home health care in their services. For instance, seven HMOs sponsored by Plans in Massachusetts and New York integrate home care benefits for Medicare beneficiaries on a case-by-case basis beyond the scope of coverage provided by Medicare. Such home care helps avoid costly hospitalization. HMOs also use management strategies such as utilization review to assure that only appropriate home care is provided.

Like HMOs, Preferred Provider products also offer opportunities for effective home health care. Such arrangements potentially would provide market leverage so that patients may receive more home care per premium dollar. We do not have the exact number but know that many Plan Preferred Provider products include home health and have negotiated contracts with home care providers. It should be remembered, however, that most preferred provider arrangements are relatively new and have concentrated on hospital and physician services.

Home Care Benefits for the Elderly

In addition to Plan HMOs' use of expanded home care for Medicare enrollees, Plans also offer Medicare supplemental policies that help beneficiaries remain at home. Many of these products cover prescription drugs, which often are essential in allowing Medicare beneficiaries to continue to live independently. UltraCare, a comprehensive Medicare supplemental product offered by Blue Cross of California, provides coverage for many services beyond the Medicare deductible and copayment. UltraCare covers prescription drugs, dental and vision care as well as a broad range of services such as home care, light housekeeping services, home delivered meals, transportation for medical care, and medical social services. These benefits are provided under a capitated arrangement using medical group practices.

Until legislation eliminated Medicare's home health deductible, visit limit, and prior-hospitalization requirement, many Plan products provided additional home care benefits in these areas.

New Home Care Benefits

Plans also are testing the expansion of home care services through a number of pilot programs. These include new services for specific populations, such as ventilator-dependent children. Infusion therapies are another new focus of coverage. These include home chemotherapy, antibiotic therapy, parenteral nutrition and enteral nutrition. These are expensive home treatments but clearly permit earlier discharge from expensive hospital care. In sum, Blue Cross and Blue Shield home care coverage is expanding to meet technological advances and patient needs but this expansion is deliberate, not casual.

Conclusion

Mr. Chairman, we are cautiously optimistic about the opportunities ahead for expanded use of home health care as an integral aspect of care for chronic conditions. We foresee further expansion of home care through Plan HMOs, Preferred Provider products, and Managed Care products. In addition, development of long term care insurance products will likely permit home care to assume an even larger role in private sector benefit programs.

In summary, we would like to provide two conclusions about our experience that may be useful as you evaluate home care within comprehensive coverage for long-term illnesses:

1. If a service is medically appropriate to provide in the home, if the at-home service helps avoid the need for care in an institution, and if effective benefit design and tight controls are used, then home care can be more comfortable but less expensive than other options.
2. Home care is a rapidly changing area, and coverage needs frequent reassessment to take best advantage of new developments. Experimentation with new methods of home care delivery and payment should be encouraged.

We hope these observations will be useful as you evaluate the role of home care in a comprehensive long-term care program. We would be glad to work with the Subcommittee as you pursue this important topic.

Mr. WYDEN. Well, thank you both very much for excellent presentations, and let me ask you both just a couple of questions.

Mr. Guildroy, I have worked with AARP on many occasions, and we always welcome you to the subcommittee. We would be interested in knowing whether AARP has seen an increase in the number of its members being denied home health care services by Medicare?

Mr. GUILDROY. I am sure that the answer is yes, Representative Wyden. We have information about this from letters and from telephone calls. Dr. Leader is closer to the situation. Her headquarters are here in Washington, if she could respond.

Mr. WYDEN. That would be very welcome.

Dr. LEADER. I cannot quantify it for you, but we have noticed a very marked increase in letters and communications from members who have been discharged unwillingly from hospitals, needing care, and have been unable to obtain home care because of varying interpretations of eligibility for home care benefits. So we are quite sensitive to this increased demand for post-acute care services that are being denied.

Mr. GUILDROY. If you would look at I think it is pages 5 and 6 of our prepared testimony, I think that you will get some idea of the interpretations that HCFA places on eligibility for home care, and how they changed, and how confusing they are. We would appreciate you doing that.

Mr. WYDEN. Mr. Guildroy, I would also be interested in knowing. You know, the deductible went up an enormous amount this year, more than—

Mr. GUILDROY. Twenty-three percent.

Mr. WYDEN. Twenty-three percent.

What have you been hearing from your members with respect to that?

Mr. GUILDROY. We have heard comments that I think that we could have anticipated. We heard these comments back in the latter part of 1985. We investigated and learned that this comes about through an inane formula that is being used to ascertain the dimensions of that deductible.

We understand that there are moves in the Congress to change that, to limit, to put a cap on increases. We certainly hope that those are successful. If you are wondering about the other side of the Medicare costs, that is the premiums on part B and the deductible, naturally we are happy that those did not go up next year, but we are not taking any bets on what might happen in 1987.

Mr. WYDEN. Just a couple of questions, if I might, for you, Ms. Field. You know, Ms. Field, every Member of Congress tries to focus on one area, and that area that I have tried to really specialize in is health care. So I have always thought that I am fairly familiar with the language and the terminology. But you have used something that I marginally understand, and maybe you could explain to me a little bit more.

What is the coordinated, comprehensive, managed care program?

Ms. FIELD. It just basically refers to a program that attempts without the restrictions on access to providers of care as in HMO's and to a lesser extent in PPO's to take what we think are the most effective types of cost containment, benefits management programs, put them together in a fashion so that they are integrated, that they work together, that they are not redundant, and you do not confuse our subscribers.

You simplify the expectations on them for such things as pre-admission review or second opinions, and try to manage it as a whole rather than as a piecemeal set of programs. So it is basically an attempt to construct for the more open choice of provider kind of benefit program which many consumers want, and the many of controls on cost that are present in more restrictive systems.

Mr. WYDEN. So there are care limitations, but open access to providers?

Ms. FIELD. Well, the care limitations tend not to be in the form of benefit restrictions like deductibles and copays as the focus. But rather in a typical program like that, you would have an individual, you would have a phone number, and if their doctor recommended that they were going to need surgery or need some other medical admission to the hospital, that they call this number. The basic details of their situation would be gotten by a nurse reviewer.

Typically then, the nurse reviewer would call the physician, and from then on would manage an evaluation of whether the admission was appropriate, whether home care might be a better alternative, or ambulatory surgery. Whether it is the type of condition given the person's circumstances where a second opinion might be advisable, in which case the subscriber would be advised.

Basically, it is an attempt to control the cost, but to do so by taking a close look at the need for services, and the appropriate location, and the timing of those services. And in that way, to avoid putting the dollar burden on the subscriber.

Mr. WYDEN. One last question, if I might.

What do you think is the driving force behind all of the new HMO's and PPO's, The health care marketplace is changing dramatically obviously, and particularly the addition of so many HMO's and PPO's I think is really incredible.

What do you think is the driving force behind this?

Ms. FIELD. Well, with the escalation of health care costs in the 1980s, everybody was floundering around trying to investigate every option there was. The Federal Government sometime ago provided a stimulus for HMO growth that was further stimulated by employers in particular dissatisfaction with the premiums that they were paying for group health.

The problem was developing HMO's rapidly in all sorts of communities. It was a much more intensive type of activity. Many people thought of reconstituting a broader idea of health coverage where you would not restrict people to a subset of providers, that you give them more of a choice with the benefit differential.

PPOS were seen as an opportunity to provide a more attractive type of program with fewer restrictions on providers access, and easier to set up in many respects. I do not want to oversimplify. They are not easy to set up. But compared to HMOs, they may require less time, less capital investment, and less geographic restrictions.

You know, I want to emphasize the other piece of this is comprehensive cost-containment programs without those kinds of restrictions. And those have certainly been stimulated in turn by the growth of HMO's and PPO's. And they are very attractive and cost containing programs when set up right.

Mr. WYDEN. Well, I just want to thank all three of you for your participation. This has really been a very, very educational and very helpful 3 hours. It seems to me that our agenda from here is really quite clear. One, short-term, we have to rebuild the interpretation of the home health care benefits. Because, I think that it really is, as we have talked about earlier this morning, death by a thousand cuts, just chipping away continually at this very small benefit, small in the beginning, and now on its way to be invisible.

That is our short-term charge. And our long-term charge, I think because of the valuable testimony and information that you have given to us here this morning, is to build a new system, catastrophic coverage, that would be available to older people and others, and have a very significant component of home care in it.

And because of the valuable information that you have given us here this morning, I think that we are a little closer to our goal. And unless you have anything to add or unless staff has anything to add, we will adjourn for the day. We are adjourned.

[Whereupon, at 12:50 p.m., the subcommittee was adjourned, subject to the call of the Chair.]

APPENDIX

Excerpted from "The Attempted Dismantling of the Medicare Home Health Benefit," submitted for the record by Val Halamandaris, President, The National Association for Home Care.

IV. THE CHRONOLOGY OF THE ATTEMPTED DISMANTLING OF THE MEDICARE HOME HEALTH BENEFIT

Over the past few years, home health agencies have been faced with a barrage of administrative actions designed to restrict services and undercut the benefits promised to senior and disabled citizens under the Medicare law. Many of these actions have been implemented by circumventing the regulatory process.

Substantive changes, which should be published for comment in the Federal Register before implementation, have informally been implemented through "guidelines" published in HCFA manuals or by written or verbal "policy directives."

Policy revisions, which are published, are frequently published as "interim final regulations," again denying the opportunity for public comment. In addition, the Department has frequently failed to adhere to other procedural requirements, such as the required analysis of a proposed rule's impact on small businesses.

This conduct violates the Administrative Procedure Act, the Regulatory Flexibility Act, the Paperwork Reduction Act of 1980, and Executive Order 12291. It hinders cost-effective and rational administration of home health agencies and of the Medicare program. And, it is the enabling mechanism for DHHS' systematic assault on the benefits mandated by Congress under Medicare.

At the outset, it should be understood that the benefit is a highly limited one. The best way to understand this is to think of the Medicare statutory entitlement as a box.

In order to qualify, the beneficiary has to fit inside this box. The left side of the home care box is the requirement that a Medicare patient qualify for "skilled nursing care." In other words, the patient must be sick enough to need the intensive nursing and medical care, as distinguished from personal care alone. One element of skilled care, for example, is that a patient must have rehabilitative potential. This is the fundamental threshold which all patients must cross enroute to coverage.

The right side of the box is defined by the term "intermittent care." In other words, the patient must not be "too sick." He or she must need care intermittently, as opposed to on a full-time basis. Patients who need care more frequently than on an intermittent basis, are thought too sick to be cared for at home and should be in a nursing home. This, of course, makes no sense as a matter of public policy. First, home health agencies are presently caring for individuals on a full-time basis when supported by non-Medicare payment sources. Second, nursing home care is not a viable option. Few people qualify for such care under Medicare. Third, if neither home care nor nursing home care are available, the ultimate effect is to leave individuals who are in need of health care to fend for themselves.

The bottom of the box is the term "homebound." In the regulations, this means that an individual qualifies for care if he/she needs the assistance of a walker, or a wheelchair, or the aid of another person to leave home. In practice, this requirement is being defined more and more restrictively to the point where it has come to mean "bedbound."

The top of the box relates to the fact that care must be ordered by a physician, and must be, in the judgment of Medicare officials, "reasonable and necessary" towards improving the patient's condition.

There were other limitations in the statute which were removed by the Congress in 1980. For example, prior to that time, for-profit agencies were not allowed to participate in Medicare unless states enacted specific laws allowing them to do so. Second, there was a limitation of 100 visits in any particular year. Third, in order to qualify for benefits, the patient first had to be hospitalized for 3 days.

In the place of these limitations, HHS has, over the last 2 years, added layer after layer of red tape, restricting the box and bringing the four sides closer and closer together until it resembles an Alfred Hitchcock elevator.

At the same time, HHS has compounded the problem by increasing the number of patients discharged into home care by 37%. The adoption of DRG reimbursement for hospitals has made this inevitable. While sicker patients are being discharged and the burden has grown, HHS has simultaneously reduced reimbursement to home health providers in a drastic way and now seeks to increase the portion of costs which must be paid out-of-pocket by beneficiaries.

HHS has justified its actions by producing a small-scale study from which it has never produced written case analyses for public review. Instead of using a large, more reliable random sample and a broader base study, HHS relies on this analysis of 39 home health agencies, which it asserts has produced results typical of all home health agencies participating in the Medicare program. The study in question suggests that some 30% of the patients receiving care under Medicare fell outside the home care box, i.e., they were either too sick, not sick enough, or not home-bound, or in the judgment of HHS officials, the care ordered by physicians and given by home health agencies was not reasonable and necessary.

The simple fact of the matter is that the box is growing smaller. HHS has pilloried home health agencies for not being within the lines and has used this as an excuse to draw the lines ever more tightly.

The real issue, of course, is money. In terms of percentages, home health care is the fastest growing part of Medicare. HHS seems intent on restricting this growth, arguing in justification that growth is fueled by proprietor greed and ignoring the fact that the growth was created by HHS itself through the implementation of the DRG reimbursement system. Saving millions of dollars by moving patients out of hospitals more quickly, HHS now seems to be trying to trim the candle at both ends, rather than accepting the modest increases in the level of home health expenditures which is the direct consequence of its own action.

HHS points to the fact that expenditures for home health care have increased from about \$1 billion in 1980 to about \$2 billion this year. It points to the growth in the number of certified home health agencies from some 3,000 in 1980 to 6,000 in 1986, and it points to the increase in average agency per-visit costs. HHS contends that these facts, taken together, are evidence that the home health benefit is out of control.

As far as the number of agencies is concerned, it is the Congress and HHS which have acted to increase their number. Analysis will show that the growth in the number of agencies falls primarily in two categories. First, proprietary agencies have increased dramatically because Congress in 1980 removed the prohibition against their participation in Medicare. Second, hospitals have more and more added their own home health agencies in order to insure continuity of care in reaction to the implementation of the DRG system.

Even though the number of agencies has increased, statistics from the Department of Health and Human Services continue to show that in excess of 5 million Americans are going without the home care that they need. In addition, there continues to be a need to create new home health agencies in rural and underserved areas. In fact, Congress has created a program which provides grants to create such agencies. Finally, the statistics used by HHS showing an increase in the number of agencies to 6,000 fail to reflect that agencies are increasingly turning away from Medicare. For the 6,000 agencies that do participate in Medicare, there may be as many as another 6,000 in the United States that do not choose to do so.

In terms of the increase in Medicare payments for home care from \$1 billion in 1980 to about \$2 billion in 1986, several points can be made. First, a 100% increase sounds large, but when one starts with such a small base, percentage increases really do not mean very much. Second, the increases by and large have resulted from the enactment of the DRG system and should be recognized as a reasonable offset to the billions of dollars saved in the Medicare hospital benefit. Third, a comparatively small percentage of the nation's 31 million Medicare beneficiaries actually benefit from home care. Last year, only about 1.2 million of the total had any utilization of the home care benefit. Fourth, home care still constitutes a tiny fraction of all Medicare expenditures, something like 3% of the total.

With respect to the increased cost to the individual agencies, it must be stated that this is logical because of the enactment of DRGs which have pushed into home care larger numbers of patients with intensive medical and nursing needs. Second, according to studies by the Department of Health and Human Services, the primary factor in the growth of agency costs is inflation. A 1984 study, for example, indicated the increase in costs shown by agencies fall into several categories as follows. 9.9 percent of the increases came from the fact that the number of individuals enrolled in Medicare had increased. Put another way, there has been approximately a 10% increase in the number of older Americans in the past 10 years. 47.5 percent of the increase resulted from the fact that more people used the Medicare home care benefit, although, as noted above, only 1.2 million of the 31 million Medicare beneficiaries actually used the service. Some 7.7% of total increased costs was the result of individuals receiving an increased number of visits. This, too, is predictable given the effect of DRGs. The remainder, or 34.9%, of the increase reflects as an increase in the average cost per visit.

A detailed analysis of the 34.9% shows that inflation accounted for 96% of all increases in the average cost per visit. Only 4% of the cost increase falls outside of that figure.

In short, HHS seems intent on reducing expenditures for home care in every way possible. HHS has placed obstacle after obstacle in the way of coverage. They have made it more difficult for beneficiaries to qualify for service. They have made it more difficult for home health agencies to provide that service. They have made it more difficult for home health agencies to be reimbursed for services that they have given. They have made it more difficult for home health agencies to appeal the denials that they have received from intermediary insurance companies. They have blocked home health agencies from assisting Medicare beneficiaries in filing appeals when they have received denials in coverage from Medicare. HHS has also increased the pressure on intermediary insurance companies to audit and to find at least \$5 in disallowed claims for every \$1 that they spend on an auditor's salary.

The aggregate effect of all of these restrictions significantly undercuts the Medicare home care benefit. Following is a short summary of actions taken by HHS to restrict the home care benefit:

(1) REMOVAL OF WAIVER OF LIABILITY PROVISION

HCFA issued proposed regulations in the Federal Register on February 12, 1985, to eliminate, in effect, waiver of liability protection for HHAs, SNFs, and hospitals. Despite overwhelming levels of comment including that of HCFA policy personnel favoring continuation of the protection, HCFA issued its final regulation, February 21, 1986, eliminating presumption of favorable waiver status.

The waiver presumption was placed in the law to protect providers who, acting in good faith, could not have known that services furnished to certain individuals would not be compensated. In these cases, the Medicare program does nothing more than make the provider whole.

In the home health setting, in order for an agency to be compensated, its overall denial of claims rate must be less than 2.5 percent of the Medicare services given. Any agency which exceeds this limit is not reimbursed irrespective of whether it accepted beneficiaries and acted in good faith. This requirement forces an agency to use due diligence in determining eligibility.

With home health agencies shifting to a system of ten new regional intermediaries, it is particularly important that the waiver presumption be preserved so that HHAs have some cushion for error as they adapt to the differing interpretations of the Medicare regulations and guidelines of their new FIS.

This proposal was advanced by the Administration for the last five years and was rejected by the Congress. Its implementation serves to further undermine both public and provider confidence in the Medicare program. It makes accepting Medicare patients a kind of "Russian Roulette" at a time when more rather than less certainty and predictability is required.

(2) APPLICATION OF THE "INTERMITTENT CARE" REQUIREMENT

In order to qualify for Medicare home care benefits, a patient must be in need of "intermittent" as opposed to daily 24 hour-a-day care. The present guidelines allow for daily visits for a maximum of three weeks. Thereafter, visits may be continued upon a showing of exceptional circumstances. Moreover, the guidelines have permitted more than one visit to the same patient on the same day, perhaps one visit from a nurse and another from an aide depending on a showing of need. Information collected from a number of States indicates that various restrictive interpretations of the term "intermittent" are being imposed by some intermediaries. In some instances, it has been used to bar more than one visit to an individual a day regardless of the justification. In other instances, clients who are in need of and who receive services 5 or even 3 days a week are being deemed as in need of daily care and therefore not compensable. There are even reports that such determinations based on restrictive interpretations are being applied retroactively resulting in retroactive denials.

The irony is that hospitals are discharging more clients who are in need of intensive nursing, physical therapy and other services into the hands of home care agencies who are being told that they cannot care for them because they need more than intermittent care. With the hospital prospective payment plan now in effect, the problem is likely to be exacerbated, with patients being released from hospitals more quickly and in sicker condition. The further irony is that government policy is pushing many clients into institutional settings when they prefer to stay at home with resulting increased costs to the government.

Definitions of what constitutes "intermittent care" vary tremendously, depending on the fiscal intermediary's interpretation. As a result, Medicare, which is supposed to be a national program, is not enforced uniformly and what is covered for one beneficiary in one state is not covered in another state.

(3) COST FINDING AND ALLOCATION ISSUES

The Medicare policy on direct or "discrete" cost-finding as part of the reimbursement methodology is causing problems for those home care agencies which also operate ancillary, non-Medicare home health businesses or non-home health programs such as preventive health programs. Medicare accounting policies are pushing costs into these programs which agencies cannot tolerate if they are to remain financially viable. This is occurring because home health agencies in preparing cost reports are not being permitted to identify those costs and programs clearly unassociated with delivering Medicare services and treat them separately or "discretely" for Medicare accounting purposes. These areas then would not absorb, through the cost allocation process of "step down," the spreading of administrative costs commonly incurred throughout the Medicare provider agency. Medicare personnel and FIS are retroactively imposing policy requirements concerning documentation and HHA business structure which have resulted in demands for large recoupments of prior payments.

Congress has stated that the cost of the Medicare program should be borne by Medicare and not passed along to other programs. The current statute and regulations do not prohibit home health agencies from using sophisticated methods of cost finding to identify costs more accurately prior to the step-down method of cost-allocation on the cost report. However, the Provider Reimbursement Manual (HCFA Pub. 15 - Sections 2308 & 2310) has prohibited use of sophisticated methods of cost finding by freestanding HHAs, even if submitted to and approved by the intermediary in advance. As a result, many agencies are forced to have an inaccurate portion of certain costs allocated under the step-down method, or to undertake corporate reorganization to separate non-Medicare costs out of the Medicare step-down methodology. HCFA's current published policy is inequitable, promotes inaccuracy and needlessly promotes corporate reorganization for reasons other than economic efficiency.

(4) SELECTIVE BILLING - BARRIERS TO COORDINATION OF BENEFITS

Fiscal intermediaries--with the approval of HCFA's Bureau of Eligibility, Reimbursement and Coverage -- are advising HHAs that if patients are receiving coverage under Medicare, in many cases they cannot receive additional coverage from Medicaid or any other payment source (private insurance, self-pay, Title XI, etc.). For example, if patient A is receiving 3 hours of nursing care and 2 hours of aide care for 3 days a week paid for by Medicare, and he or his family wants an additional 2 hours of nursing care on the other 2 days which will be paid by concerned relatives, Medicare intermediaries will deny the Medicare coverage. This either will result in no care, limited care, or the forced institutionalization of an individual whose family cannot sustain him at home if Medicare refuses to pay its fair share.

Medicare's logic for such denials is that if a person receives care beyond what Medicare will cover, then the person needs more than "intermittent care" and is ineligible for Medicare coverage. Thus, Medicare is seeking to both prescribe the need (i.e., the limits of intermittent care) and to be second payor. This approach limits the availability of services to beneficiaries and availability of payment sources to beneficiaries and HHAs. Furthermore, the Medicare intermediaries will deem this a "technical" denial depriving the HHA of a right of appeal.

There is no basis for the "selective billing" policy in law or regulations. It exceeds the authority granted to HCFA and its fiscal intermediaries. To allow such a policy to exist makes the Medicare benefit "means-tested," which clearly is not the intent of the existing law.

The current policy discriminates against home health agencies because it seeks to deny coordination of payment sources for benefits, while such coordination is permitted for hospitals and under the new Medicare hospice benefit. The law makes no such distinction between hospitals, hospices and home health agencies.

Further, the current policy is illogical. Where the patient receives his Medicare-covered care from one HHA and other covered care (paid from non-Medicare sources) from another HHA, both HHAs are paid and the patient receives his full coverage from all payment sources. It is illogical not to allow such coordination of benefits where the care is being rendered through one HHA.

(5) DISALLOWANCES OF APPROPRIATE ADMINISTRATIVE COSTS

HCFA has endorsed policies to create Medicare disallowances of reasonable and appropriate administrative costs associated with the business of patient care. Examples of areas of disallowance are (a) portions of dietitians' time spent doing in-field assessments but not billed as visits; (b) costs of educational conferences discussing improvements to management of health services delivery; (c) costs of participating in local health planning agencies' certificate of need proceedings; (d) reasonable compensation screens and their application.

Congress intended Medicare beneficiaries to receive the highest level medical services based upon this need, delivered in an efficient manner. Reasonable administrative costs common in the industry and necessary to the proper running

of a business dealing in patient care are reimbursable according to clear statutory language and Congressional intent. HCFA disallowances of the kind listed are not legally supportable, and HCFA should rescind any guidelines or directives to fiscal intermediaries which have endorsed such disallowances.

(6) HMO PARTICIPATION IN THE MEDICARE PROGRAM

HCFA published a proposed rule in the May 25, 1984 Federal Register (at page 22198) regarding participation in the Medicare program by Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs). The final rule appeared in the January 10, 1985 Federal Register Volume 50 at page 1314. The rule allows HMOs and CMPs to receive a prepaid amount for serving Medicare clients, provided the HMO makes available all services and benefits required by Medicare. The regulation requires that when such an HMO contracts out provision of Medicare home health services, it must do so with a Medicare-certified HHA. However, if an HMO decides to provide the home health services internally, its home health component need not be separately certified under Medicare. As of January, 1986, no mechanism has been developed or published by HCFA or DHHS for ensuring that the HMO component home health services meet appropriate quality, frequency, administrative and other standards for Medicare beneficiaries. HCFA has stated in communications with NAHC that HMO-component home health services will have to meet the HHA conditions of participation, but no method for measuring and no responsible branch of government have been identified.

HCFA's failure to require an impartial demonstration as part of its HMO certification that an HMO meets the home health conditions of participation if the HMO provides home care from in-house raises serious quality of care issues, including the potential use of inappropriately trained and supervised independent contractors. It also puts Medicare-certified HHAs at a competitive disadvantage because they must incur the time and expense of meeting Medicare conditions of participation and applicable state HHA licensure and CON requirements. The quality of care issue becomes an even greater problem in states without HHA state licensure requirements because in such states Medicare HHA certification is the only control. NAHC believes the regulations should require any HMO providing home care from in-house sources to be reviewed and to show it meets the Medicare HHA conditions of participation as part of the HMO's certification process (not that the HMO's HHA would have to be a separately certified Medicare HHA). If the regulations are not so amended, corrective legislation, including state HMO licensure requirements of dealing with certified HHAs, should be pursued.

(7) PLAN OF TREATMENT AND DOCUMENTATION GUIDELINES FORMS 485-488

The home care industry endured a major HCFA administrative disaster in 1984 and early 1985 due to HCFA's attempt to force implementation of the poorly designed data elements forms 443 & 444. HCFA agreed to rescind forms 443-446 and to redesign the plan of treatment and medical information forms. This was undertaken in a 3-day workgroup session in March, 1985. HHAs were represented, as were certain of the fiscal intermediaries and HCFA regional office personnel. However, no major outside computer consultant group was brought to the workshop by HCFA or consulted in depth during the design period. The workgroup was presented with an outline of a form from which they had to work, rather than being asked for original design suggestions.

A parade of bureaucratic errors has ensued:

- * The strongest recommendation of the workgroup -- that there be a field test of the design protocol -- was disregarded by HCFA.
- * A rigid September 1, 1985 date for implementation was announced by former HCFA Administrator Carolyn Davis, and HCFA Bureau staff said no practical difficulties encountered would permit delay of that date.
- * The other longstanding and frequently reiterated comment by NAHC that there be an extensive period for review and instruction on the guidelines for use of the forms was not heeded by HCFA staff.
- * Instructions were not available until July, 1985.
- * No hardcopy training and explanation guidelines were provided the FIs, who received oral training only.
- * Supplies of the forms and instructions were very late in reaching the providers in the field.
- * No schedule of training sessions by the FIs was demanded or even recorded by central HCFA staff.
- * In most states, training sessions were given close to or even after the September 1 starting date for use of the form.

- * Multiple areas of confusion and massive difficulties with the design, the physical quality of the forms and particularly the computer specifications, were identified by providers and FIs and communicated by NAHC to central HCFA. The response was that the industry would have to do the best it could, that costs of implementation were not being measured by HCFA and the industry would have to present whatever facts it could on administrative burden.
- * HCFA's computer division in the Bureau of Program Operations continued insisting -- despite unanimous comments from HHAs, FIs and computer companies -- that there was no problem with the computer process for use and transmission of the forms.

NAHC's survey of the HHA cost and time impact demonstrates huge administrative burdens created both by the use of this form as designed and by the implementation fiasco. Early indications from the trial quarter of 1985 (the first 3 months of use) are that FIs are issuing massive denials without utilizing the form 488 or other methods of seeking medical documentation. Processing of claims by FIs has slowed to as much as 25% of the prior processing rate -- 4 to 8 week turnaround times are reported by FIs. Despite assurances from central HCFA that FIs have been instructed to be "flexible" and "lenient," the contrary has occurred. Requests for accelerated advance payments are being denied. HHAs are expending huge amounts of time and money to deal with this documentation crisis -- while being paid at new lows under cost caps which did not include this kind of administrative expense.

While NAHC recognizes and supports the interest HCFA has in using universal forms which may be processed consistently and which could provide important data, bureaucratic errors and unrealistic adherence to timetables in this situation have caused extensive and unnecessary confusion and massive expense. Home health providers and beneficiaries should bear no part of these costs.

(8) DESIGN AND IMPLEMENTATION OF A SYSTEM OF TEN OR FEWER INTERMEDIARIES FOR HOME HEALTH AGENCIES

Pursuant to Section 2326(b) of the Omnibus Deficit Reduction Act of 1984 (P.L. 98-369 -- signed into law July 18, 1984), HHS is taking action to alter the current 47 designated intermediaries system for Medicare home health agencies to a system of ten or fewer intermediaries (FIs) by no later than July 1, 1987. NAHC filed extensive written comments and met frequently with HCFA in 1985 concerning its planned new system, scheduled for implementation during fiscal year 1986. In the final notice, published February 13, 1986, HCFA responded to some but not all the issues. NAHC remains concerned about: the selection of very small organizations with little experience with HHAs to service large volume areas; the computer capability of the selected organizations; the ability of HHAs to choose an alternate FI without extensive HCFA resistance; and the failure of HCFA to consider serious conflicts of interest between certain FIs, which are major health service deliverers as well as insurance companies, and the HHA health service providers they will be monitoring.

NAHC continues to believe any system to implement the Section 2326(b) mandate should have been promulgated as a regulation pursuant to the Administrative Procedure Act (APA). HCFA's "proposed notice" with comment period and the extensive communications it has had on the issue was useful but did not permit an initial period of comment and proposal from the home care community prior to the initial tentative ten intermediaries selected by HCFA. No formal request for proposals (RFP) was issued by HCFA to the 47 FIs, some of which might have placed useful information on the record for comment.

HCFA must ensure a transition which is legally sound, operationally smooth and cost-effective, and which does not cause undue disruption to the cash flow and overall operation of HHAs and intermediaries.

(9) COVERAGE COMPLIANCE REVIEW GUIDELINES AND AUDITS

In December, 1984, HCFA changed the coverage compliance review requirements. Transmittal 328 revised Section 2300.1 - 2300.5 of the Medicare Intermediary Manual, Part 2 (HCFA Pub. 13-2). Among other changes, the revision mandated five home visits to beneficiaries (without notice to HHAs); reduced from 5 working days to a 24 hours in advance phone call the notice to an HHA that an on-site review would be conducted; deleted the random selection requirement for the 20 beneficiaries being reviewed and allowed "any in-house source deemed appropriate" to be used as a basis for selecting requirement for the 20 beneficiaries being reviewed; lengthened the time period within which 3 months of sequential billings/beneficiary should be selected from the most current 3 months to the most current six months; and added Medicare home health aide utilization as a fourth ranking criterion in the selection of HHAs for on-site review.

Valid and reliable statistical techniques should be used in on-site reviews where the results of the sample findings can affect an HHA's PIP, waiver and 100 percent review status. Reasonable advance notice is necessary as a matter of equity, and to ensure that proper staff and records are available. NAHC believes many of

the revisions create an inequitable situation, are based on statistically invalid and unreliable sampling techniques, and deny the HHA adequate notice to prepare appropriate records and staff and to accompany review staff to beneficiary homes. NAHC has begun to record numerous examples of coverage compliance audits under the new guidelines which have been conducted unfairly with massive, inappropriate denials. The on-site audits also have generated additional administrative burdens for the agencies because of agency staff overtime, agency-supplied transportation demanded for auditors and photocopying demands of Medicare auditors. Some form of informal appeal or review should be permitted of the often unreasonable denials and criticisms made by on-site reviewers.

(10) TECHNICAL DENIALS

HCFA policy makers have created a form of coverage denial called "technical denials" which are increasingly being imposed on HHAs. A technical denial of a visit is based on the FI's determination that the visit failed to meet a statutory or regulatory requirement other than medical necessity. By HCFA edict, technical denials are not subject to payment under waiver of liability and are appealable only by the beneficiary. Examples of "technical" denials are those where the FI finds the client did not meet the homebound or "in need of intermittent skilled nursing care" eligibility requirements despite the fact that the home health agency has made a professional medical judgment that the patient has done so. Other "technical" denials may be based on the FI's determination that the patient received a non-skilled or other service not covered under the Medicare home health benefit. Recently, HCFA has directed FIs to treat as "technical denials" home health aide visits monitored as part of a skilled service which the FI denies but pays under waiver. This effectively abolishes any opportunity for the provider to appeal any aspect of the associated denials, and has resulted in extensive financial harm to many HHAs.

(11) INABILITY TO APPEAL CLAIMS PAID UNDER WAIVER

Under current HCFA guidelines (Section 256, HIM-11), an HHA has no right to appeal a claim denial if it is paid on waiver. HCFA asserts the HHA paid under waiver has no liability, is not at risk and therefore, should not have the right to appeal. This situation is exacerbated by the fact that particularly controversial denials often are paid under and charged to waiver immediately before the opportunity for the administrative review or reconsideration procedure. Often the claims paid under waiver are for services rendered many months before the FI processes the claims. The same services have continued to be rendered to those and other beneficiaries in intervening months and may be considered medically necessary by the provider and certifying physician on a current or future basis. HHAs should be given the right to directly appeal FI decisions to pay by waiver instead of regular payment because there is no statutory or regulatory basis for the HCFA guideline. In addition, the logic is incorrect, because there is harm to HHAs. When claims are paid under waiver, they affect the HHAs' waiver level and can push them over the 2.5 percent threshold. This can result in the loss of waiver, affect eligibility for PIP and increase the administrative burden, all of which have significant impact on cash flow, particularly for small agencies. Third, absent statutory authority to the contrary, the HHA should have, as a matter of basic equity, the right to dispute an FI's decision on whether to pay a claim under normal payment or waiver.

(12) INABILITY TO HAVE WAIVER STATUS RECORD ADMINISTRATIVELY ADJUSTED

FIs retroactively take HHAs off waiver where the FIs made errors in honoring claims which should have been disallowed. However, FIs will not enter in the HHA's records the fact that waiver status was erroneously denied because the FI (or an Administrative Law Judge) has reversed the claim denials which caused the loss of waiver. In one of many examples, a Chicago-based HHA lost its waiver because of 85 visit denials in one quarter. After going to hearings, a total of 87 percent of the denials were reversed. If there had been a retroactive adjustment to the affected quarter, the denial rate would have dropped from 4.66 percent to 1.86 percent. The HHA received reimbursement for the reversed denials, but there was no entry in the HHA's records that the waiver status was erroneously lost for the affected quarters.

Sequential loss of waiver can result in adverse effects on PIP qualification.

Where subsequent appellate actions find the initial loss of waiver or the rate was wrong, an administrative restoration of the HHA's waiver status or rate should be put in writing in the HHA's record (and all other applicable records) so as not to jeopardize the HHA. Such a correction of records is a matter of equity and proper administration of the Medicare program. The number of times an agency loses waiver and/or the rate at which it exceeds the 2.5 percent level is used to determine an HHA's eligibility for or continuation on PIP, whether it will be selected for a coverage compliance review and whether it will be selected for review by the Office of Health Financing Integrity or other HCFA reviewers.

(13) FAILURE TO PAY CLAIMS WHEN HHA IS UNDER WAIVER

If an FI reviews an HHA's claims and finds that the HHA is within the 2.5% error rate, the claims subsequently reviewed and denied are payable while the HHA is under waiver unless the FI has evidence the provider knew or had reason to know that a particular claim was not covered under Medicare. (This is the essence of the favorable waiver status.) The FI which believes the provider should not have particular claims paid because of "knowledge" has an obligation under the regulations to show how the provider "knew" the particular services for that particular patient were not medically reasonable and necessary. However, HCFA recently has stated that an FI is correct in sending an HHA on waiver a blanket denial letter without providing identification of the specifics which preclude payment under waiver. HCFA acknowledges the FI must have justification "in the files" but sees no reason to have the information communicated with the initial denial letter.

An HHA under waiver as a result of favorable demonstration of ability to make coverage decisions has both a right under the regulation to be paid for inadvertent (but statistically infrequent) errors on coverage decisions and a right to be informed sufficiently by the FI of "knowing" errors so that the HHA can attempt to preserve its accuracy in coverage determinations. HCFA cannot defeat presumptive regulatory rights, and should not place the obligation on providers to investigate the FI's files without a specific rebuttal on specific facts demonstrating an HHA "knew" of non-coverage either by prior, unreversed denials of particular services of the same kind, or by a manual or other communication concerning specific services which were deemed noncovered in all instances.

(14) HCFA'S FAILURE TO USE STANDARD STATISTICAL STANDARDS OF VALIDITY AND RELIABILITY IN PERMISSIBLE SAMPLING METHODOLOGIES

HCFA does not use generally accepted statistical standards of validity and reliability in most home care programs where it uses sampling. These include the sampling used in fiscal audits; in the post-payment review process; in the on-site coverage compliance reviews; in the conduct of various research projects examining home health policies and procedures; and in the fiscal intermediary evaluation program (CPEP). Changes in the method for determining waiver of liability status have some, but not all, of the necessary components of acceptable statistical sampling. As a result, the findings of these programs cannot statistically be relied upon to reflect the actual operations of HHAs and intermediaries. Nevertheless, these invalid or partially valid and unreliable methodologies are used as a basis to deny claims, project overpayments, decide an agency's waiver and/or PIP status, and decide if a HHA is eligible for PIP or should be subject to 100% review.

Generally accepted statistical standards are necessary to give an accurate measure of the behavior of HHAs and intermediaries in order to develop appropriate corrective measures. Invalid and unreliable sampling techniques will result in actions which are inappropriate and may be unnecessarily punitive to HHAs.

(15) BONDING AND ESCROW REQUIREMENTS

On November 25, 1985 HCFA issued a notice of proposed rulemaking in Volume 50 of the Federal Register at page 48435, which would require financial security arrangements for HHAs in the following circumstance:

1. HHAs in existence less than three years, as evidenced by having less than three settled cost reports, would be required to have a bond or escrow account in an amount of 10% of estimated Medicare costs for their first year.
2. HHAs with year end, cost report overpayment recoupment demands from FIs of 15% or greater of the HHA's Medicare costs in any of the last three years would be required to post security for an amount equal to the largest overpayment in that period.
3. HHAs with 85 percent or higher Medicare utilization (measured by visits) would be required to post bond or obtain an escrow account unless they could demonstrate they had not had a significant overpayment or had repaid any without borrowing.

Although NAHC is firmly behind reasonable efforts to safeguard the Medicare Trust Fund, and to forestall any occasion in which home health agencies (HHAs) intentionally operate to jeopardize the financial security of the home care system, the proposed regulations are:

- (a) Insufficiently Supported in Fact; both in the background materials supplied in the proposed regulation and in the historical record in recent years, to support so stringent a requirement. By HCFA's own admission, only 9 percent of HHAs report significant overpayment in a year, and the number of HHAs that actually default is a

much smaller number than that. However, the regulation would require approximately 4500 HHAs to be bonded during the initial three years of their status as "newly established" HHAs or by virtue of their high Medicare utilization.

A miniscule number of home health agencies (32 in the 1965-1980 period) proportionate to the more than 5875 now certified have actually fully defaulted on Medicare debts. Existing Medicare repayment procedures ensure both return of monies and interest to the Medicare Trust Fund; flexibility in granting longer term repayment schedules permit agencies to remain viable and deliver necessary services to beneficiaries without disruptions in care. No current rising tide of defaulting HHAs exists. In stark contrast, NAHC is aware of thousands of HHAs experiencing extensive delays in the processing of their claims by Medicare FIS. (Hundreds are considering or have already secured loans to cover immediate costs of payrolls.)

* The proposed regulation requirement that each subunit of a HHA must establish its own financial security arrangements ignores the financial viability that a parent organization may be able to demonstrate over time. Absent a justification and demonstration of the HCFA factual basis for this requirement, NAHC finds it unsupported.

- (b) Overly Broad and Restrictive. If any financial security arrangements were imposed, they should be prospective only in their application.

* "New" home health agencies receiving initial Medicare certification after the implementation of such a regulation should be subject to the requirements for no more than one year as evidenced by one finalized cost report.

* HHAs with "significant" overpayments. Factual inquiry is necessary to identify the causative elements outside the activity of an individual HHA which may contribute to a HHA's development of significant overpayment problems. These elements include: (1) whether the fiscal intermediary has been attentive and effective as a monitor of newly established HHAs by properly instructing and reviewing accounts from these agencies; (2) whether the existence or presumption of waiver status for newly established HHAs ought instead to be delayed until after an initial period of demonstrated competence; (3) what the history has been of the FIS providing accurate coverage determinations (including the FIS' rate of reversal on reconsideration or administrative law judge proceedings); (4) and finally to what degree central HCFA policy guidelines have been vague or non-existent in serious areas of concern such as "discrete costing" of non-Medicare costs on the provider cost report and related documentation requirements communicated unclearly to the provider community. Many major overpayment disputes involving HHAs have flowed from clear failures to communicate programmatic requirements, retroactive shifts in program policy, and announcements of program requirements which do not match industry practice over time.

- (c) Unjustified if Applied Because of Medicare Utilization Equal to or Greater than 85 percent of Visits.

* Although the initial Congressional concern may have, in part, focused upon providers which are heavily Medicare-dependent, in fact the development and utilization of the Medicare home care benefit has been endorsed by Congress, and its delivery made possible by home care providers willing to accept the less than full reimbursement rates available under Medicare as a result of the cost limits schedules.

* The proposed restrictions would virtually eliminate the agencies which are small, privately owned, those county or state-based and others particularly devoted to community care. This sort of HHA has remained devoted to servicing the Medicare beneficiary, has no "deep pocket" resources to fund an escrow account and may be legally barred from doing so, if government-based.

* This portion of the proposed regulation is a first step toward rationing care without appropriate Congressional action for such an undertaking. Congress would not support a narrowing of the home health benefit, and this regulation attempts to do so indirectly.

* The proposed methods by which a high Medicare-utilizing HHA could exempt itself are so vague as to be a virtual guarantee of inconsistent and, therefore, unfair application nationwide.

(d) Not Feasible to Implement Due to Lack of Available Financing Sources.

* HCFA has presented no evidence suggesting that it has researched the availability of bonding and the availability of income sources for escrow accounts for the home health providers it proposes to cover by the proposed Rule. NAHC has found, as did its predecessor organization, the National Association of Home Health Agencies (NAHHA) which surveyed HHAs in 1981, that bonding simply is not available to home health providers in current financial markets. The cost figures HCFA reports in its proposed regulation of \$20 per \$1,000 certainly are no longer available for any provider market.

* HHAs cannot find willing lenders in current times, since HHAs are facing: (1) major cash flow problems associated with the new HCFA Forms 485-488, which have had such a difficult implementation period; (2) rising number of denials and documentation requests issued by fiscal intermediaries; and (3) the necessity to seek short-term loans to meet these cash flow problems associated with HCFA administrative changes. All have rendered the possibility of raising significant funds to place in an escrow account highly improbable.

The enormous number of regulatory changes and restrictions imposed on HHAs in 1985 have continuing impact in 1986 and, including UB-82, the new cost limits methodology and the new FI system, make it less likely now than in 1981 that agencies - especially small rural agencies -- would be able to obtain a bond or capital for an escrow account.

(e) Restrictive of Agencies' Rights in Seeking an Appeal of Medicare Disagreements.

The imposition of major financial requirements, such as the creation of an escrow account, for HHAs which have entered into a re-payment arrangement but which are planning to contest the underlying issues which have led to their overpayment status, especially unusual, or significant policy determinations by Medicare policy personnel -- such as the utilization of retroactive "discrete costing" requirements or the utilization of statistical sampling projections -- places HHAs in a position in which their appeal rights may be abridged if they are forced to divert limited financial resources to an escrow account, rather than to support of their appeal.

(f) Administratively Expensive and Inequitable.

* The requirements, as outlined, will be extremely expensive for the FIs to administer and extremely expensive for HHAs at a time of rising administrative costs associated with new documentation requirements. The added non-reimbursable expenses will be another expensive demand on certified HHAs, reducing or eliminating their ability to bid competitively for contracts with health care systems such as HMOs.

* The regulation requires skills and judgment from FIs in areas involving financial assessments, long-range financial viability and management potential of businesses, legality of arrangements of indebtedness, and other related factors for which FI employees are not educated or prepared.

* The vague, and in some cases legally questionable, discussion of "guarantee agreements" in the proposed rule suggests HCFA has not analyzed how such arrangements might affect not-for-profit organizations and their tax status or the ability of certain corporate organizations to serve as guarantors of their subsidiaries.

Without documented and demonstrable need for such additional, costly financial burdens on home health agencies, the proposed regulation is unjustified and detrimental to the Medicare beneficiary and home health agencies.

(16) ABRIDGEMENT OF APPEAL RIGHTS OF PROVIDERS AND BENEFICIARIES

There are numerous situations in which the Department of Health and Human Services and its agents have acted to obliterate, discourage or skew the existing appeal process available under Medicare statutory provisions and regulations.

1. Projections of Part A Claims Denials onto Universe of Claims

Fiscal intermediaries under HCFA direction have reviewed individual beneficiary Part A cases in several home health agencies and, finding alleged coverage questions in a small percentage of sampled cases, have projected those denials over all the visits and claims of a home health agency throughout its cost year. This means unknown beneficiaries' care and unknown coverage "errors" cannot be appealed on their facts by Medicare beneficiaries or the providers. Appeal rights for Part A Medicare claims of beneficiaries and providers which Congress has established by law, 42 U.S.C. Section 1395 pp, are obliterated. (See Section VI(1))

2. Interference with Appeal Process

HCFA has attempted to interject itself in various appeal procedures where, by the Department's own regulations, there is no HCFA role: (a) at administrative law judge (ALJ) proceedings for review of claims denials, (b) in petitions to the Appeals Council asking it to reverse ALJ opinions favoring providers and beneficiaries. The Appeals Council, by regulation, is an independent entity that reviews ALJ decisions on its own motion or by request of providers or beneficiaries only.

3. Discouraging Exercise of Appeal Rights

(A) Questions are being sent to Medicare beneficiaries who request reconsideration of Medicare claims denials -- the very first level of appeal. The HCFA-designed questionnaire asks verification of signature, asks for the content of any communication about the appeal between the beneficiary and the home health agency which had served him/her, and ends with the disquieting inquiry "Do you still wish to have reconsideration of this claim?" This communication is directed to an elderly, infirm population of beneficiaries who frequently can be easily alarmed, intimidated or dissuaded from asserting their rights in an aggressive fashion. There is an obvious breach of privacy attempted in the questioning. Beneficiary groups with which NAHC has communicated, such as the National Senior Citizens Law Center, are outraged. No regulation makes the sending or responding to such an inquiry part of the appeals process. No authorization to use such a questionnaire was obtained from the Office of Management and Budget under paperwork requirements.

(B) Certain administrative law judges from the Department's Office of Hearings and Appeals phoned beneficiaries and their families telling them that pursuing their appeal rights through a hearing was not in their best interests. No Departmental directive was issued nationally to warn that an ALJ acting in such a fashion bridges legal rights.

4. Forbidding Appeal

The coverage denial determination for claims paid under waiver is not subject to appellate review according to HCFA. (See 11 above).

5. Forbidding Provider Appeals of "Technical Denials" (See 10 above)

6. Forbidding Beneficiaries to Name HHA as Representatives in the Appeal Process (See 22 below)

HCFA has been acting without legal authority in each of these areas affecting appeal rights.

(17) INTERMEDIATE SANCTIONS FOR HOME HEALTH AGENCIES PRIOR TO TERMINATION FROM MEDICARE PROGRAM

Pursuant to HCFA Manual instructions (HIM-11, section 142.2), HCFA may terminate a participating provider agreement with an HHA if it is determined, among other situations, that the HHA "is not complying substantially with the provisions of the agreement" or with applicable provisions of the Medicare statute or regulations, or if the HHA "no longer meets the appropriate conditions of participation." The termination is effective 15 days after notification to the agency, and the manual provides no reconsideration prior to available appeal procedures, under Medicare regulations 42 CFR section 405, subpart O. Because of numerous stringent interpretations and variations of interpretation under state surveying practices or federal validation review, an HHA may be alleged to have gone out of compliance with one or more of the Medicare conditions of participation but pose no immediate, actual and documentable risk or threat to the health or safety of any patient. Nonetheless, the Medicare program personnel currently interpret the Medicare regulation's requirement that an HHA be in compliance with the conditions as an absolute, permitting no interim period of agency functioning during the administrative appeal process.

Medicare certification of an HHA functions as the practical equivalent of licensure, and for a reputable HHA to be abruptly deprived of certification without an opportunity to work toward correcting alleged deficiencies, disrupts patient care and unfairly damages agency viability. Court opinions permitting termination of Medicare program participation prior to a formal hearing have focused upon the acute care, in-patient setting, such as nursing homes, in which full responsibility and control over every aspect of a patient's life lies with that institution. Only in a rare circumstance is an HHA likely to pose a comparable immediate threat of harm to a patient's safety and well-being.

(18) APPLICATION OF THE "HOMEBOUND" REQUIREMENT

A 1979 GAO Report recommended that the homebound requirement for home care be deleted. In 1981, a GAO Report criticized the homebound guideline (Section 208.4 of HIM-11) as being unclear and vague, causing inconsistent interpretations in coverage decisions.

In July, 1983 HCFA circulated internally a proposed new guideline that would have changed the Section 208.4 (HIM-11) guideline defining "homebound."

The new guideline would have reversed the existing presumption that a person need not be totally dependent and bedridden to be considered homebound. It would have done so by deleting the current guideline wording that to be homebound "the condition of these patients should be such that there exists a normal inability to leave home and consequently, leaving their home would be a considerable and taxing effort." The current guideline allows the patient to be considered homebound if he has infrequent or short duration absences from the home primarily for medical treatment or "occasional non-medical purposes" (e.g., trip to barber, a drive, walk around the block). NAHC believes this is a reasonable approach which balances the ability to have limited activity while being essentially confined to one's home and eligible for Medicare home health benefits.

(19) APPLICATION OF THE "SKILLED NURSING" REQUIREMENT

Every Congress going back to the 92nd Congress has gone on record in favor of an adjustment in the priority of government funding which has favored placing Medicare and Medicaid patients in institutions. Despite the progress that has been made towards encouragement of home care, the primary impediment to the delivery of home health services is a restrictive interpretation of "skilled nursing."

Some FIS say "skilled nursing" means "hands-on" care only and are denying any evaluation or assessment visits where the evaluation visit is followed by care. Some FIS are saying if more than one visit a day is needed, then the care is not skilled care because institutional care is needed. And some are assuming that if a family member/relative/friend exists, he can be taught regardless of any assessment of the nature of the procedure and the person's abilities. Other FIS are defining specific activities, which HHAs believe require trained nurses, as those which either a home health aide, relative, or family member could do. And other FIS are defining persons as "chronically unstable" and therefore not eligible for skilled nursing care because more than "intermittent skilled nursing care" is needed. In some states, the Medicare interpretation of skilled nursing activity contradicts the State Nurse Practice Acts.

(20) USE OF "VISITS" AS BASIS FOR BILLING HOME HEALTH AIDE SERVICES

HHAs currently are required to use a "visit" basis when filing for home health aide services in the cost report since the cost caps are based on visits.

Prior to this requirement, HHAs could use an hourly basis. The current requirement helps some HHAs and harms others. For the ones it harms, one reason is that some Medicaid and other State programs, and private insurers require an hourly basis for home health aide visits. The result is that (a) there is additional accounting time and paperwork, (b) there is a loss of funds where aides are paid on an hourly basis and the number of hours per visit exceeds the visit cap, and (c) the method can cost the Medicare program more money than is equitable. Furthermore, when the requirements of a homemaker-home health aide are properly divided between hours in the morning and hours in the afternoon or evening (transferring a patient from bed to chair, for example), some FIS consider the split time as two visits and disallow one. This problem has increased with the data entries on HCFA Forms 485-488.

HHAs should be reimbursed for their reasonable costs since the Medicare home health benefit is reimbursed on a cost-based system. The inability to allow for conversion of hourly costs into visit cost runs counter to the cost-based system and financially penalizes HHAs.

(21) LACK OF ADEQUATE STANDARDS FOR FISCAL INTERMEDIARIES

The current law, regulations and guidelines do not contain specific, binding timeframes within which fiscal intermediaries must process claims, respond to HHA or beneficiary inquiries, or process reconsiderations. Ranges of time periods

for responses by FIs are counted in their year end contractor evaluations (CPEP), but these are utilized for review purposes by HCFA and are not mandates for action. Thus, FI delay in meeting a reasonable time standard for payment of an HHA claim does not result in automatic payment issuing to the HHA. On the other hand, HHAs are held to specific time limits in terms of claims submissions, provision of supplemental claim data and filing of reconsideration requests.

Timeliness standards are essential for the efficient and effective operation of HHAs, including maintenance of an adequate cash flow and having notice as soon as possible on coverage policies as manifested in claims denial decisions. The latter is necessary to properly advise HHA staff of new or revised interpretations so they can appropriately adjust the nature and frequency of visits.

NAHC has called on HCFA, in NAHC comments on the move to a 10 Regional FI system, to require specificity in denial notices. This is crucial to achieving Congress's goal of greater consistency and cost effectiveness in a 10 FI system. NAHC will make this issue a central one in meetings with HCFA on the transition to 10 FIs. If HCFA does not achieve these goals through administrative directive, the regulation should be changed to:

- (A) Require that either the denial notice and/or appropriate accompanying papers from the FI must specify each visit denied and the specific reason for each visit denial;
- (B) Require that denial notices be sent to HHAs and patients in a timely manner, and in understandable language; and
- (C) Require that HHAs get notification of denials prior to or, at a minimum, simultaneous with notification to patients.

The intent of 42 CFR section 405.702 was to give the HHAs and beneficiaries a specific basis for requesting a review or appeal and initiating corrective action in staff policies/procedures where necessary. The lack of specificity subverts the intent of the regulation and the rights of the appellate process.

(22) ABILITY OF BENEFICIARIES TO DESIGNATE HHA EMPLOYEES AS REPRESENTATIVES IN THE CLAIMS APPEAL PROCESS

In January, 1984, HCFA issued a revision to HIM-11 (Transmittal 150 changing Sections 257-A of HIM-11) which prohibits Medicare beneficiaries from designating HHA employees to represent them in the claims denial appeal process. Similar revision to Manuals were issued dealing with SNF and hospital employees. The rationale was that such representation per se represents a conflict of interest.

The Section 257A issuance is in violation of the law and should be corrected to restore full and appropriate rights to both beneficiaries and HHAs. It is also unconstitutional in terms of its lack of promulgation through the Federal Administrative Procedure Act process, and in terms of the existing regulation allowing beneficiaries to designate representatives.

(23) LACK OF CLEAR STANDARDS IN THE PERIODIC INTERIM PAYMENT PROGRAM

An even cash flow is vital to the survival of home health agencies. In recognition of this fact, HCFA has allowed agencies with good performance records to receive payments in advance which are computed on the basis of past billings. The current regulations governing initial and continuing eligibility for the Periodic Interim Payment (PIP) program set only general criteria (42 CFR section 405.454). This results in individual intermediaries developing and implementing their own and varying specific criteria relating to such issues as: relationship of waiver status to PIP eligibility, criteria for evaluating requests for increases in PIP payment levels, timeliness of claims submission criteria, and handling of overpayment and underpayment adjustments to PIP, among other issues.

In many circumstances, the criteria were not even disseminated in writing with FI justification for the particular restrictions or requirements in keeping with the regulation. In the second half of 1985, some fiscal intermediaries refused to process requests to go on or adjust PIP, claiming they need not process requests while the fiscal intermediary system was being revamped and centralized to 10 regional intermediaries. New rules announced by HCFA would restrict the availability of PIP only to those agencies which have electronic (computer) billing capability. Most home health agencies do not have this capability and most of the intermediaries that will be processing their claims do not have adequate ability as of yet to process such claims electronically.

Further, on January 10th, NAHC received from HCFA a copy of Transmittal 1254, amending Section 3603 of the Intermediary Manual, HIM 13-3, to set out "timeliness" criteria for providers billing submission related to PIP eligibility. Dated December, 1985 with a January 1, 1986 effective date, the "30 days from date of service" language, linked to a requirement that bills pass FI edits, completely disregards the Form 485 crisis.

There should be a set of specific standard criteria which are equitable, reflect the intent of PIP, and are applicable to all intermediaries. NAHC and other concerned parties should be permitted to have input in the creation of any manual guidelines to the interpretation of the PIP regulation. The January, 1986 manual revision violates these notions of equity and fair process.

(24) INCREASING, EXCESSIVE, INCONSISTENT DENIALS OF COVERAGE

Home health agencies throughout the country have experienced new forms and alarming increases of denials of coverage for home visits. Fiscal intermediaries are issuing blanket denials of what is clearly skilled and medically necessary care of the type and intensity for which coverage was approved in prior years by the same intermediaries reviewing equally detailed cases. Fiscal intermediaries are also issuing partial denials, reducing approved payments from 3 to 2 visits per week, for example, despite physician orders for the greater number of visits and demonstrated need in the given case. Such partial and complete denials have not been preceded by any communication from HCFA or the FIs as to medical, scientific or regulatory bases for changes in coverage policy. Furthermore, FIs in different states are handling similar coverage situations differently, continuing the national pattern of inconsistent policy application.

Fiscal intermediaries are responding to HCFA's pressures to lower the total dollar amount of Medicare home health services approved, despite Medicare beneficiaries' entitlement under the statute to the full range of medically necessary home care. To satisfy immediate HCFA demands for "savings," FIs are issuing arbitrary and erroneous coverage decisions which then must be appealed -- an unnecessary increase of the long-term administrative costs of Medicare.

It is unfair to beneficiaries and home care providers, and administratively unsound, to develop and apply HCFA coverage policy in an intangible, retroactively announced fashion. It is unfair for HCFA to expect fiscal intermediaries to return \$5 in "savings" for every \$1 in administrative "costs" to the Medicare program with a rapidly growing Medicare population now receiving health services at home. Fiscal intermediaries should be provided with clear, consistent written instructions on the range of treatments and diagnostic conditions for which HCFA develops coverage policies of limitation of payment. These HCFA policies should be developed in keeping with statutes and regulations after open, detailed discussions with clinicians and administrative personnel from the home care setting.

CONCLUSION

These actions by the Department of Health and Human Services reflect the administration of policy in an arbitrary and capricious manner. The net effect is to subvert the intent of Congress in establishing the home health benefit under Medicare and restrict service unfairly at a time of explosive need.

For the beneficiary, our seniors and disabled, it all too often means being forced out of the hospital by the incentives of the prospective payment system for hospitals and denied the necessary continuing support services in the community.

By analogy, the Department is widening the care gap between the hospital and the community with one set of policies and blowing up the bridge with the other.



IN HOME HEALTH CARE SERVICE OF SUBURBAN CHICAGO NORTH, INC.

A NON PROFIT ORGANIZATION

(312) 955 8250

VISITING NURSES
PHYSICAL THERAPY
OCCUPATIONAL THERAPY
SPEECH THERAPY
MEDICAL SOCIAL WORK
HOME HEALTH AIDES
NUTRITIONAL GUIDANCE

Honorable Claude Pepper
House Committee on Aging
Washington, D.C. 20515

Dear Mr. Chairman:

Normally, this would be the week that I, along with many other Home Health Agency directors, would be in Washington to discuss our needs with you and what we would recommend for the continuity and necessary expansion of Home Care.

This year, my visit with you will have to be by the written word. This Agency, along with the majority of others, can't afford the expense of the trip. As a matter of fact, 70% of the Medicare certified home health agencies are facing severe financial consequences or worse. This is due to the litany of rules, regulations, procedural changes and changes in reimbursement since July, 1985 promulgated by the Health Care Financing Administration (HCFA).

Since July, 1985 HCFA has promulgated:

1. Elimination of the Aggregation of Cost Caps; and a
2. Change in the methodology of the Cost Caps resulting in an approximate 5.3% decrease in the maximum reimbursement levels for home health agencies in Cook and DuPage Counties, Illinois; and they
3. Installed an ill-designed, ill-conceived uniform documentation and certification form(s) and procedures (Forms 485, 486, 487); and they
4. Installed a new uniform billing form (UB-82) at the same time as the documentation form; and they have
5. Eliminated the provisions of protection under Waiver of Liability (patients already having lost the right to designate home health agency personnel to represent them in denial cases); and a
6. Change of the current Intermediary system to just 10 Fiscal Intermediaries, some not to well qualified; and their
7. Interpretation of the 1% reduction of reimbursement under Gramm-Rudman-Hollings; and the
8. Escrow and Bonding requirements with the attendant costs not to be includable as a reasonable cost.

The combined effects of these initiatives are devastating to the Home Health Agency. Medicare reimburses home health agencies (the vast majority being non-profit) its costs based upon, and subject to a Medicare audit of reasonableness.

136 North Grove Center

8700 Waukegan Road

Morton Grove, Ill. 60053

1. The loss of aggregation will create a permanent financial deficit in current operations for at least 70% of the home health agencies in this country. At least that many are over cost caps in at least one discipline, yet, under aggregate cost caps. For this Agency, the loss equals approximately 1.33% of our costs for the first two months of 1986. The cost cap for Home Health Aides was reduced by 8.77% for this Fiscal Year. All of this Agency's HHA staff have been with us for at least 9 years. I would have to let them go for new, untrained, cheaper staff to get under cost caps, and possibly incur discrimination litigation. We need the ability to subsidize a high cost discipline or we must eliminate the discipline which will have an adverse effect upon our patients. Morally, I can't terminate my present staff for cheaper staff and I can't, in good conscience deprive our patients of this much needed service. Without aggregation, survival to the end of this year is impossible.
2. HCFA accomplished a severe cost reduction for home care when it changed the method for determining the cost caps from the 75th percentile to the 120th percentile of the mean (115th next year and 112th the following year). The new method is based upon old financial information, not considering the costs forced upon home health agencies by HCFA with its new rules and forms. The recent increases in insurance (Liability, Workmans Comp., etc.) rents, utilities, payroll taxes and health insurances were also not included.
- 3 & 4. The new forms (485, 486, 487) for documentation do not even line up in a computer printer, must be constantly changed back and forth, do not contain the appropriate space for proper elaboration, and have increased this Agency's clerical cost by one full-time equivalent and the related fringe benefits. The additional cost of approximately \$17,300 annually was not contemplated in the cost caps but, "the exception process is available".
5. Medicare now suggests that home health agencies should now have 100% perfect judgement and never make a mistake. We have to be 97.5% perfect now. The old and infirm, not being able to avail themselves of the representation of their home health agency (HCFA HIM-11 transmittal 150) are left to fend for themselves, facing loss of services, and in many cases ending back in an institution. At least there is some room for legitimate discussion of what is reasonable care. Without the provisions for Waiver, home health agencies will be caught in the trap of financial survival (no denied visits) versus what the patient really needs (risk of loss). The patients lose.
6. The additional burdens placed upon the designated ten Fiscal Intermediaries will require an increase in claims adjudication personnel. There will not be enough time to properly train or educate the new personnel in home care. This will cause increased denials of patient visits, not just for the agencies that are changing intermediaries and getting adjusted, but also for those that aren't making the change. The increased costs incurred by those agencies forced to make the change are not exempted for cost cap limits but "the exception process is available".
7. On top of that HCFA's interpretation of the Gramm-Rudman-Hollings 1% reduction is for every \$1.00 of reimbursable expense (subject to

cost cap limits and non-aggregated) this Agency is going to receive \$0.99. And, as the need for care increases due to the poor condition of the patients at the time of hospital discharge, the Agency has the opportunity to increase our losses with volume. To make matters worse, HCFA will be cutting our interim rates of reimbursement by 1%, and now, in order to make payroll and pay mandatory bills, this Agency will have to borrow money and pay interest on that debt, which will again add to our costs and the whole downward cycle.

8. Finally, under new proposed rules on Escrow and Bonding HCFA will be requiring the majority of home health agencies to provide them with a Surety against over-reimbursement. The cost of this bond is not includable as a reasonable cost, and the cost of the premiums are very expensive, if you are fortunate enough to find an entity willing to offer such a bond under these circumstances.

This may sound overly dramatic but the situation, the condition and the prognosis, as of right now, are all true.

WE NEED YOUR HELP!

NOW!

The Home Health Industry needs your support for legislation that will:

1. Restore aggregation to the Cost Caps; and
2. Eliminate the application of the Gramm-Rudman-Hollings to cost reimbursed (Home Health Care) programs; and
3. Freeze the Cost Caps at last years level, without changes; and
4. Preserve the provisions of Waiver of Liability, and restore the patient's right of choice of representation; and
5. Prohibit the proposed rules for Escrow and Bonding (and the related costs) from taking effect.

With great respect for your faith in Home Health Care, I remain.....

Charles Laff
Executive Director



Town of Groton

45 FORT HILL ROAD

• GROTON, CONNECTICUT 06340

TEL. 203 448-8881

March 25, 1986

V. J. Halamandaris, President
 Nat'l. Assoc. for Home Care
 919 C St., N.E. Stanton Park
 Washington, D.C. 20020

Dear Mr. Halamandaris:

The members of the Groton Town Council wish to bring to your attention recent medicare policy restrictions which have had an adverse effect on the delivery of patient care services.

Medicare policy restrictions have caused a decline in patient eligibility for the Medicare program. Changes include:

- 1) Stricter interpretation of regulations by Blue Cross/Blue Shield of Connecticut, which is the designated fiscal intermediary for the Town of Groton. Interpretations of the definition of intermittent care and eligibility for homebound programs has drastically reduced the amount of coverage that can be provided. Rather than reducing the types of illnesses eligible for homebound care under Medicare, consideration should be given to increasing the eligible illnesses such as Alzheimers Disease and others.
- 2) Increased paperwork requirements have lowered the productivity of the visiting nurse staff and have increased operating costs.
- 3) Claims denials have increased.
- 4) There has been a general slowdown in the processing of claims and payments.
- 5) The waiver of liability has been eliminated.
- 6) Lastly, due to the Gramm-Rudman-Hollings deficit reduction law, effective March 1, 1986, a 1 % cut in medicare claims payments was implemented.

We would ask your assistance in overcoming these newly designed impediments to the delivery of cost effective patient care services.

If you would like to discuss our concerns on this issue in greater detail please do not hesitate to contact Patricia O'Connor, Executive Director, Groton Public Health Nursing Service, Inc. at (203)536-4268.

Sincerely yours,

Eric A. Robba ^{ad}

Eric A. Robba, Mayor
 Town of Groton

5/2/86